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MEDICAL READINESS PLANNING AND TRAINING

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This instruction implements Air Force Policy Directive (AFPD) 41-1, *Health Care Programs and Resources*, Department of Defense (DoD) Directive 6010.17, *National Disaster Medical System (NDMS)*, December 28, 1988, DoD Instruction 1322.24, *Military Medical Readiness Skills Training*, and DoD Directive 1215.4, *Medical Training in the Reserve Components*, November 29, 1990. It sets procedures for medical readiness planning and training for peacetime and wartime contingency operations. This instruction may be supplemented by headquarters (HQ), Reserve Component (RC), and major command (MAJCOM) specific guidance. **Records Disposition.** Maintain and dispose of records created as a result of processes prescribed by this instruction IAW AFMAN 37-139, "*Records Disposition Schedule*."

This instruction requires collecting and maintaining information protected by the Privacy Act of 1974 authorized by Title 10, United States Code, Section 8013. System of Records notice F012 AF B, Privacy Act Request File, applies.

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Chapter 1

FUNCTIONAL AREA RESPONSIBILITIES

1.1. US Air Force Surgeon General (HQ USAF/SG). This individual will:

1.1.1. Establish medical policy.

1.1.2. Obtain and allocate resources.

1.1.3. Evaluate Air Force Medical Service (AFMS) support capabilities.

1.1.4. Establish a committee to annually review AFMS medical readiness training programs to ensure such programs are adequately designed to fulfill defined medical readiness training requirements.

1.1.4.1. This committee shall update the medical readiness training community on current training initiatives as well as function as a forum to discuss and make recommendations for resolution of medical readiness training issues.

1.2. US Air Force Inspection Agency (HQ AFIA/SG). This agency will:

1.2.1. Assess the efficacy of HQ USAF/SG and HQ AFIA/SG approved reporting and tracking systems.

1.2.2. Assess medical unit capability to respond to disaster situations and wartime contingencies.

1.2.3. Evaluate unit implementation of medical readiness policies and procedures.

1.2.4. Comply with pertinent items of AFI 90-201, Inspections.

1.2.5. Provide oversight and guidance to MAJCOMs that inspect using AFIA standards.

1.3. Major Command Surgeons (MAJCOM/SG), and Air National Guard Air Surgeon (ANG/SG) (NOTE: ANG is considered a MAJCOM throughout this instruction) . These individuals will:

1.3.1. Provide policy to all subordinate commands and medical unit commanders on all aspects of medical readiness.

1.3.2. Ensure medical units' and facilities' capability to provide or arrange for care of casualties resulting from contingencies, in both war and operations other than war.

1.3.3. Ensure that medical personnel can carry out all aspects of their assigned contingency missions.

1.3.4. Arrange for medical support and assistance to subordinate units in case of a natural disaster, major accident, enemy attack, or other contingency.

1.3.5. Evaluate and monitor adequacy of medical plans, readiness, and the training status of units.

1.3.6. Ensure that medical units comply with this instruction, as well as *(S)USAF War and Mobilization Plan(U),* Vol 1 (WMP-1) policy, operation plan (OPLAN) requirements, and other applicable directives.

1.3.7. Authorize appropriate subordinate units with Contingency Hospital/Air Force Theater Hospital missions to designate executive management team positions for those hospitals. The positions designated are on the unit manning document of the facility that provides the UTC. Eligible personnel within MAJCOM resources will fill these positions.

1.3.8. Develop and issue preventive medicine guidelines for each area of responsibility and for operations and exercises outside CONUS (OCONUS).

1.3.9. Assist unit level Medical Readiness Officers (MRO), Medical Readiness Non-Commissioned Officers (MRNCO), and civilian Medical Readiness Managers (MRM) to resolve any problems with the readiness program.

1.3.10. Publish and review DOC Statements IAW AFI 10-201, *Status of Resources and Training System (SORTS).*

1.3.11. Review all Medical Contingency Response Plans (MCRP) prior to publication (as specified in para 1.10.1).

1.3.12. Review and ensure generation mission staffing is adequate and identified on the Unit Manning Document (UMD) per paragraph 3.1.2.

1.3.13. ANG/SG review MAJCOM directives that affect Reserve Component (RC) units to determine applicability of requirements.

1.3.14. MAJCOMs have the authority to grant waivers of up to six months for all requirements identified in this instruction.

1.4. Air Force Personnel Center Medical Director (HQ AFPC/DPAMNE). This individual will:

1.4.1. Review and approve applications for Category I Continuing Medical Education (CME) credit for medical readiness training (MRT) courses. This office also maintains published guidance outlining the process for submitting applications. Personnel should always consider applicability of MRT to CME or Continuing Education Unit (CEU) credit.

1.5. Medical Treatment Facility (MTF) Commanders, Aeromedical Evacuation Commanders, or Medical Unit Commander (SG). This individual will:

1.5.1. Establish and maintain the capability to provide or arrange for care of casualties resulting from contingencies, in both war and operations other than war.

1.5.1.1. All exercise and training requirements in this instruction will be completed on a twelve-month cycle unless stated otherwise. Specific problems meeting these requirements will be forwarded to the MAJCOM SG for guidance.

1.5.2. Publish a Medical Contingency Response Plan (MCRP) and provide medical input to Base Support Plans and base-level mission planning documents. Send copies of appropriate unit plans to gained units, which include the units identified to provide support during contingency operations. Also send a copy of contingency plans to the parent MAJCOM of each gained unit.

1.5.2.1. Reserve Component (RC) medical units need not prepare these plans, but should be listed as a resource in plans of collocated active duty medical units. Indicate the number and Air Force Specialty Code (AFSC) of the RC unit personnel in the active duty unit MCRP. Non-collocated RC units reflect their disaster response capability in the applicable base-level plans. All RC units will document their wartime missions in the parent wing mobilization plan.

1.5.2.2. Active duty medical units must forward copies of all unit plans that deal with RC augmentation to the applicable RC units.

1.5.3. Ensure that assigned and attached RC medical units and Individual Mobilization Augmentee (IMA) personnel receive the same priority for MRT as active duty medical personnel and receive training which meets established requirements. The primary focus of RC training in medical treatment facilities will be AFSC-specific sustainment training.

1.5.4. Evaluate unit readiness and ensure that personnel can perform wartime and peacetime responsibilities.

1.5.5. Provide duty-specific training to all non-medical personnel who will augment the medical facility in wartime or during peacetime disasters or emergencies.

1.5.6. Provide professional and technical guidelines to disaster response force personnel and deployment personnel on the medical aspects of both peacetime and wartime contingency operations.

1.5.7. Appoint an MRO, MRNCO, and civilian MRM, as applicable, and ensure appointees attend course J30ZR4000-005, Medical Readiness Planning Course (MRPC). Medical Service Corps officers who received medical readiness training during Comprehensive Functional Area Training (CFAT) at the Health Services Administration Course will be considered trained. Ensure course attendance within one year of appointment (available class quotas may prohibit attendance within this time frame.). Documentation of application and denial of course attendance due to non-availability of training slots must be on file in the medical readiness office.

1.5.8. Establish and chair a Medical Readiness Staff Function (MRSF) at each active duty medical unit. RC medical commanders should make sure that RC medical units address medical readiness issues quarterly as a standing agenda item of Executive Management Committee meetings. (See para 1.10. for membership)

1.5.9. Appoint a Medical Intelligence Officer (MIO). Not applicable to AE.

1.5.9.1. (Deployed MTF Commander) Ensures that disease statistics are reported from the deployed MTF following guidance found in paragraph 4.12.3.

1.5.10. Appoint a Nuclear, Biological, Chemical (NBC) Medical Defense Officer (MDO) or NCO. The Bioenvironmental Engineer (BEE) should be appointed; however, the unit commander can appoint a qualified BEE technician. If no BEE personnel are assigned, contact the Command BEE for guidance. Not applicable to AE.

1.5.11. Provide a Bioenvironmental Engineering (BEE) personnel to assist the Civil Engineering Readiness Flight with the development of the installation NBC detection plan and to perform NBC surveillance. Provide BEE personnel to the Wing Survival Recovery Center (SRC) and to the Wing NBC Cell and NBC reconnaissance teams to augment CE readiness personnel in NBC detection, identification, and analysis. If a unit has no BEE, the Civil Engineering Readiness Flight consults with the Command BEE for guidance. Not applicable to AE.

1.5.12. Provide technical policy to installation commanders on protection, personnel risk assessment, and operations in NBC environments.

1.5.13. Medical units with tasking to perform casualty decontamination will assign decontamination team members IAW the manpower formula given for Unit Type Code (UTC) FFGLB. Decontamination procedures, equipment, and training sets will be based on the Air Combat Command Concept of Operations for Wartime Casualty Decontamination.

1.5.13.1. Ensure equipment items such as the Chemical Agent Monitors (CAM) are tested/operated on a weekly basis to verify operability.

1.5.14. Coordinate with the Base Civil Engineering Squadron, base fire department, an assigned medical provider (physician, PA, or NP), and Bioenvironmental Engineering concerning Peacetime Hazardous Materiel (HAZMAT) Response. The BEE should be the primary medical focal point on HAZMAT issues. Determine procedures for receiving patients after decontamination by base HAZMAT (fire department) personnel.

1.5.15. Ensure PH and BEE personnel, in coordination with Services and Civil Engineering, conduct food and water vulnerability studies for employment sites and fixed installations.

1.5.16. Assign personnel to meet each deployment tasking as outlined in OPLANs and MAJCOM tasking documents.

1.5.17. Coordinate with base MIO to ensure that applicable preventive medicine guidance is provided to unit personnel during pre-deployment, deployment, and post-deployment.

1.5.18. Verify that pre-deployment medical screening and immunization requirements for all deploying personnel (medical and non-medical) are identified and completed. This would include, but not be limited to DNA sampling, HIV testing, tuberculin skin testing, and medical/dental and mental health screening. The Chief, Professional Services has primary responsibility for the establishment of the process for this activity. The Physical Exams Office has primary responsibility for carrying out the established process, in conjunction with dental, mental health, immunization and laboratory assistance.

1.5.19. Appoint representatives to the Wing Exercise Evaluation Team IAW local requirements. Team members should not be members of the medical readiness office, but the medical readiness staff should be consulted to ensure exercise objectives fully test medical readiness and fulfill exercise requirements, as outlined in this instruction. The team chief should be an officer or senior NCO and have full knowledge of exercise requirements for medical personnel.

1.5.20. Annually review and initial the Designed Operational Capability (DOC) Statement.

1.5.21. Review, certify accuracy, and approve unit Status of Resources and Training System (SORTS) reports IAW AFI 10-201 and MAJCOM supplements.

1.5.22. Designate the Self Aid/Buddy Care monitor. (May not be applicable to some AE units, co-located with other non-AE medical units).

1.5.23. Units should program for medical readiness Staff Assistance Visits (SAV) through their respective MAJCOMs.

1.5.24. Conduct the wing chemical-biological quantitative fit training (QNFT) program IAW AFI 32-4006.

1.6. Squadron Commanders. This individual will:

1.6.1. Ensure squadron members are fully trained for mission support.

1.6.2. Support participation of personnel in formal and informal medical readiness training courses and events, to include local training, sustainment training associated with wartime, Small Scale Con-

tingencies (SSC), Non-combatant Evacuation Operations (NEO) and humanitarian operations other than war (HOOTW).

1.6.3. Provide appropriate support to the MRO, MRNCO, or MRM to ensure the success of the medical readiness program.

1.6.4. Apprise the MTF SG of problems at the squadron level that adversely impact the overall medical readiness state of the unit.

1.6.5. Ensure appropriate Annexes in the unit and Wing plans are reviewed to meet mission requirements.

1.6.6. Participate in the Medical Readiness Staff Function.

1.6.7. Screen members assigned to deployment positions to determine if they have been convicted of "a misdemeanor crime of domestic violence." If yes, they may not fill deployment positions IAW the Amended Gun Control Act of 1968, 30 Sep 96.

1.7. The Medical Readiness Officer (MRO), Medical Readiness Non-Commissioned Officer (MRNCO), and Medical Readiness Manager (MRM), henceforth called the MR Office unless a paragraph is addressing one of them specifically. These individuals will:

1.7.1. Manage the preparation and publication of the MCRP and mission-specific plans. Team chiefs responsible for specific functions will write the annexes.

1.7.2. Coordinate internal unit review of the Base Support Plan (BSP), consolidate medical inputs, and submit appropriate changes to the base plans office. At a minimum, the Executive Staff, MRSF, and team leaders must review the BSP on an annual basis.

1.7.3. Coordinate with medical logistics staff to ensure timely submission of War Reserve Materiel information for medical capability reporting. Not applicable to the RC, see para **1.5.2.1.**

1.7.4. Incorporate AFSC specific training into the unit annual medical readiness training plan and schedule.

1.7.5. Prepare the medical information needed for base-level mission planning documents.

1.7.6. Prepare the medical deployment operating procedures for the base deployment plan. Not applicable to AE.

1.7.7. Ensure that disaster team training programs are developed, conducted, and properly documented. Not applicable to AE.

1.7.8. Evaluate and document unit medical readiness training.

1.7.9. Ensure Medical Readiness Decision Support System (MRDSS) data is appropriately updated each month, as significant changes occur (defined as 25 percent or greater), and accurately reflects the unit's status on organizing, equipping, and training to support its wartime tasking. Present the information to the Executive Staff on a monthly basis (NLT the last duty day of each month) and Medical Readiness Staff Function (MRSF) members. ANG and AFRC members will submit their information to the Executive Management Committee. AFRC will provide specific guidance concerning the use of MRDSS.

1.7.10. Integrate the Medical Readiness portion of the AFIA/SG Health Services Inspection Guide into the unit self-inspection program. Not applicable to AE.

1.7.11. Attend J30ZR4000-005, Medical Readiness Planner's Course (MRPC), upon first time assignment to MRO/MRNCO/MRM duties (see para **1.5.7.**).

1.7.12. Coordinate development and approval of medical readiness support agreements with civilian and base agencies. Compliance with applicable Department of Defense, Federal, State, and Local directives must be ensured when drafting the documents. Ensure annual review of established agreements is conducted, at a minimum, by the Executive Staff and MRSF. Not applicable to AE.

1.7.13. Develop an annual medical readiness training and exercise schedule. Also serves as the primary office of responsibility for development of the unit Continuing Medical Readiness Training (CMRT) program.

1.7.14. Prepare and submit an error-free SORTS report IAW AFI 10-201.

1.7.14.1. Request comeback copies of unit SORTS data after submission and review it for accuracy.

1.7.14.2. Contact the Wing SORTS manager with any error.

1.8. Medical Intelligence Officer (MIO). This individual will (not applicable toAE):

1.8.1. Before deployments, work with line intelligence personnel to establish an AFMIC Medical Intelligence product requirement statement. Use all medical intelligence sources available to prepare the medical threat assessments for deployment locations so that medical risks are included in pre-deployment threat briefs.

1.8.2. Provide pre-deployment preventive medicine briefings to all deploying personnel.

1.8.3. Upon arrival at the deployment location, assist the unit commander in planning site selection and facility set-up to facilitate sanitation/hygiene. If the MIO who performs pre-deployment planning is not the same MIO that deploys, ensure coordination of information. All activities involving disease surveillance will be reported through the appropriate chain of command, IAW the appropriate Annex Q of the OPLAN/EXPLAN.

1.8.4. During the deployment, compile and analyze incidence of diseases, illnesses, injuries, or any other degradation of human performance. All activities involving disease surveillance will be reported through the appropriate chain of command. When appropriate, maintain a high suspicion for Biological Warfare Agents. The MIO is at the forefront of biological warfare detection.

1.8.4.1. Inform the medical commander of any medical threat to personnel.

1.8.5. After deployment to overseas locations, work with medical personnel to complete the After Action Report as directed in paragraph 4.13, this document.

NOTE: This requirement applies to units returning from overseas deployments.

1.8.6. For RC units without a Public Health Officer, select the best qualified individual to work with their primary support active duty unit. The RC unit designee should request to share medical intelligence information. The RC unit representative will accomplish all the duties cited for the active duty MIO.

1.8.7. Personnel assigned Medical Intelligence duties must attend the USAFSAM Public Health Contingency Operations Course and the AFMIC Medical Intelligence Course within one year of assignment. The Apprentice course or the AFMIC's Medical Intelligence Course may be attended by the

MIO/NCO for RC forces in lieu of the PHOT or CPHO if their civilian employment is as PH technicians/technologists.

1.9. The Nuclear, Biological, Chemical (NBC) Medical Defense Officer (MDO) and NCO. These individuals will (not applicable to AE):

1.9.1. Provide or supervise NBC training in the medical unit training program.

1.9.2. The NBC MDO or NCO shall identify and make known to physician trainers, physicians, and/or other medical operational personnel (including NCOs) applicable formal training opportunities to which they may make application. This includes courses on prevention and/or treatment of casualties of Weapons of Mass Destruction (WMD) to include nuclear, biological, and chemical. Formal courses are available through USAMRIID, Ft. Detrick, MD, for infectious disease and biologicals and through the Institute of Chemical Defense at Aberdeen, MD, for chemical. Formal courses are available in-residence, locally where trainers are available, or through distance learning.

1.9.3. Evaluate NBC aspects of medical planning and the effectiveness of training.

1.9.4. Work closely with base Civil Engineering Readiness Flight personnel to verify that base NBC training and medical NBC training provide consistent instruction.

1.10. Medical Readiness Staff Function (MRSF). The chairperson of the MRSF is the medical unit commander (SG). All efforts will be made to schedule MRSF meetings to assure the SG is available to attend the meetings. In the absence of the commander, the acting SG chairs this function. The MRSF includes the Executive Management Team, the MR Office, the MIO, the NBC MDO, the Director/Chief of Medical Logistics, Chief of the MTF or Squadron Exercise Evaluation Team, Reserve Component liaison (if applicable) and any others selected by the unit commander. RC MRSF responsibilities are fulfilled through the Executive Management Committee, with medical readiness included as a standing agenda item. The MRSF will:

1.10.1. Set guidelines for preparing medical unit plans (re-written every two years). Review (annually) and approve all plans and annexes before publication. Document this review in MRSF minutes.

1.10.2. Evaluate medical unit preparedness and recommend improvements. Medical readiness indicators provided in the Medical Readiness Decision Support System (MRDSS) will provide data for this evaluation (see para 4.2). Review of MRDSS (MEDSTAT for AFRC) reports must be conducted monthly by the SG to include assessment of action plans for identified problems. SG will notify their respective MAJCOM Surgeons if MAJCOM assistance is required to correct identified medical readiness concerns.

1.10.3. Monitor and evaluate unit medical readiness training and review Centralized Credentials Quality Assurance System (CCQAS) readiness data, and recommend improvements or corrective actions for medical readiness training deficiencies. Additional information may be provided by the unit Education and Training Office as it relates to formalized training that is clearly linked to sustainment training, i.e., Advanced Trauma Life Support (ATLS), Advanced Cardiac Life Support (ACLS), Basic Life Support (BLS), and Combat Trauma Life Support (CTLS). The annual training plan shall be forwarded by the MRSF to the MAJCOM/SGX for approval prior to the new calendar year.

1.10.4. Review and approve the unit readiness exercise program, including planning, execution, and follow-up corrective actions. The annual exercise schedule shall be approved prior to the new calendar year. Dates should be flexible to allow for changes to the base exercise calendar.

1.10.5. Meet formally, at a minimum of every other month. Review of MRDSS medical readiness indicators must be conducted monthly. Formal discussions of information will occur at the MRSF meeting. MAJCOMs can set additional guidelines for MRSF activities.

1.10.6. MRSF Minutes. Meeting minutes should provide a clear, concise summary of discussions and events. Use MRSF minutes to document unit MCRP review and approval, as well as training and exercise schedule coordination and approval. The minutes should reflect reporting and tracking of exercise and inspection findings, and document corrective actions approved by the MRSF. Attachments should include copies of Post Incident/Exercise Involvement Summaries, After Action Reports, schedules, calendars, presentations, and database products presented to the MRSF. Minutes should include the following, as applicable:

1.10.6.1. Status of unit medical readiness training

1.10.6.2. Results of inspections, incident responses, and exercises

1.10.6.3. SORTS update (ensure all members in attendance have proper clearance before presentation of information)

1.10.6.4. MRDSS update (to include indicator system review)

1.10.6.5. MEDSTAT update (applicable to the RC only)

1.10.7. A copy of the MRSF minutes will be sent to the MAJCOM/SGX for review. (Not applicable to the RC)

1.11. HQ Air Education and Training Command Surgeon (HQ AETC/SG), 882 Medical Training Group (TRG), HQ Air Force Materiel Command Surgeon (HQ AFMC/SG) and US Air Force School of Aerospace Medicine (USAFSAM). These individuals and organizations will:

1.11.1. Coordinate with MAJCOMs for the review of formal courses to verify that identified peacetime and wartime training requirements are being addressed through course development and implementation.

1.11.2. Develop and provide current medical readiness training materials for use by medical units.

1.11.3. Recommend ways to improve or enhance the Air Force Medical Service peacetime and wartime disaster response capability. Send recommendations to: HQ USAF/SGXR, 170 Luke Avenue Suite 400, Bolling AFB, DC 20332-5113.

1.11.4. Develop training programs that support the overall medical service role in existing operations plans. Verify that training programs develop the skills personnel will need to accomplish peacetime and wartime missions. Appropriate coordination of medical readiness training activities with other in-house training offices will greatly assist in avoiding redundancy in training efforts.

1.11.5. Update the designated HQ USAF oversight group on planned or proposed changes to formal courses.

Chapter 2

THE PLANNING PROCESS: OVERVIEW OF PROCEDURES, GUIDANCE, AND RESPONSIBILITIES

2.1. Planning Responsibilities of the Air Force Medical Service (AFMS). The Air Force Medical Service is responsible for planning and providing the medical support necessary to sustain maximum combat capability and effectiveness. The medical planning process must encompass all aspects of medical support for peacetime and wartime contingency operations. MAJCOM and unit-level mission planning documents support and supplement HQ USAF policies and publications.

2.1.1. The following documents cover planning for peacetime and wartime contingency operations:

2.1.1.1. *USAF War and Mobilization Plan,* volume 1 (WMP-1), Annex F and Joint Chiefs of Staff (JCS) Publication 1-04, *Medical Support in Joint Operations* describe the wartime concept of operations for the medical service.

2.1.1.2. AFPD 32-40, *Disaster Preparedness* and AFI 32-4001, *Disaster Preparedness Planning and Operations* describe the Air Force Disaster Preparedness (DP) Program. Medical planners apply these policies and procedures for peacetime and wartime planning and operations.

2.1.1.3. AFPD 10-1, *Air Force Readiness Program* and AFI 10-212, *Air Base Operability* describes the Air Force Air Base Operability (ABO) Program. Medical planners apply these policies and procedures to wartime planning and operations.

2.1.1.4. AFPD 10-4, *Operations Planning* and AFI 10-403, *Deployment Planning* describe deployment planning policies and procedures. Medical planners use these documents along with MAJCOM and base-level mission planning documents to develop procedures for mobilizing medical personnel in wartime.

2.1.1.5. AFI 10-404, *Base Support Planning,* identifies a base's total support capability and an assessment of the base's ability to support either a most demanding contingency operation or a number of specific contingency operations with the identified resources.

2.1.1.6. AFI 36-2250, *Civil-Military Innovative Readiness Training (IRT),* describes the policies and procedures for deploying RC assets in support of civilian activities.

2.1.1.7. All US Air Force MTFs address medical support for peacetime and wartime contingencies in the unit MCRP, as described in this chapter.

2.1.1.8. See chapter 3 of this instruction for information on documents applicable to CONUS medical support.

2.2. Medical Contingency Response Plan (MCRP). The MCRP establishes procedures for peacetime disaster response as well as providing policy and local procedures for medical operations in time of war (MCRP format is at attachment 2). Medical responses to all contingencies in which the MTF may be involved are covered except actions required in CONUS for survival, recovery, and reconstitution (SRR). US Air Force SRR Plan 55 and supporting MAJCOM plans specify medical operations for SRR. Non-collocated RC units describe their disaster response in applicable base plans. ANG units use base and state guidance to document this information. Collocated RC medical units are listed as a manpower

resource (when present for duty) in the MCRP of the active duty unit. Medical planners can identify and train RC personnel to augment specific MCRP teams.

2.2.1. Responsibilities, missions and tasks shall be included in the plan. Reference the Base Support Plan and include base operations support not outlined in that plan.

2.2.2. AFSOC Operational Support Medical Flights (OSM) do not publish a MCRP. These units use the AFSOC Medical Concept of Operations. This CONOPS is reviewed and updated annually by HQ AFSOC/SG.

2.2.2.1. AFSOC Medical Operations Officers and Special Operations Forces Medical Elements (SOFME) provide appropriate medical input to applicable base wing and/or line unit plans. This may include plans for exercises, theater response, and the various SOF deployments requiring medical support.

2.2.3. Submit the MCRP and/or CONOPs to the MAJCOM for review prior to publication. Plans reviews should be accomplished by MAJCOMs within 60 days. If no response from the MAJCOM is received within that period, concurrence is implied.

2.3. Distribution and Maintenance of the MCRP and Supporting Checklists. The MRO/MRNCO/MRM will oversee distribution and maintenance of this information for the medical unit.

2.3.1. Distribute copies of the MCRP as follows:

2.3.1.1. Medical unit commander or deputy commander.

2.3.1.2. MR Office (including additional copies for transfer to the shelter, alternate medical facility, and deployment location, as applicable).

2.3.1.3. Medical Control Center.

2.3.1.4. Disaster Team Chiefs (Team Chiefs review/update their respective checklists at least once a year).

2.3.1.5. Parent MAJCOM.

2.3.1.6. Contributing organizations or units (including RC) listed in the plan.

2.3.1.7. Base Civil Engineering Readiness Flight Office.

2.3.1.8. Wing Plans Office.

2.3.2. Each medical unit currently OPLAN-tasked to augment an overseas unit should request a copy of the deployed location MCRP.

2.3.3. Maintain master checklist sets, consisting of all team checklists as follows:

2.3.3.1. One set for MCC operations.

2.3.3.2. One set each for transfer to the shelter, alternate medical facility, and deployment location.

2.3.3.3. One set for use by the MR Office.

2.3.3.4. One set for Battle Staff/Crisis Action Team (CAT).

2.3.3.5. One set for the Exercise Evaluation Team Chief.

2.3.4. Verify that individual team checklists describing their specific functions are readily available to team members and augmentees.

2.3.5. Review checklists at least once a year and update as necessary following plan review and update. AF Form 2519, **All Purpose Checklist**, may be used as a template for creating team checklists.

2.4. Declaration of Death in Wartime. In wartime, a physician may not always be available to declare death. In order to avoid unnecessary delays in initial death processing and moving remains, the medical unit must identify other qualified medical professionals to declare death.

2.4.1. In addition to physicians, qualified medical personnel include Dental Corps officers, Nurse Corps officers and Biomedical Sciences Corps officers (physician assistants). Also, specific enlisted personnel involved in far-forward casualty care and casualty evacuation (CASEVAC) operations may be required to make provisional declaration of death while triaging casualties and making CASEVAC decisions. This may include: AFSOC SOFME, independent duty medical technicians (IDMT), pararescuemen, and other personnel with current certification as an Emergency Medical Technician-Paramedic (EMT-P).

2.4.2. The medical unit commander, or equivalent medical authority (such as the senior physician), will review the qualifications of medical professional before authorizing them to declare death.

2.5. Use of Medical Technicians as Security Force Augmentees. Consistent with AFI 10-217, medical technicians may be called upon to augment security forces. The following guidance is applicable in the planning process for deployed medical forces and should be briefed to medical personnel subject to deployment.

2.5.1. IAW the Geneva Convention, Article 22, medical personnel can be given small arms to act in self defense and the defense of sick and wounded, medical supplies, and facilities. In such cases, medical personnel can act as pickets or sentries in those roles and retain their protected status.

2.5.2. If medical personnel step away from this role and engage in offensive operations or other duties inconsistent with the above, they lose their protected status and should surrender documentation indicating they are protected medical personnel under the Geneva Convention.

2.5.3. Should they engage in augmentee duty such as supplementing Security Force personnel manning entry control points, patrolling the base perimeter, and standing guard over strategic resources, they lose protected status.

2.5.4. Upon return to medical duties (including protecting the sick and wounded, medical supplies, and facilities, they regain their protected status and their Geneva Convention documents can be returned to them.

Chapter 3

CONTINENTAL UNITED STATES (CONUS) MEDICAL SUPPORT

3.1. Wartime Mission of the US Air Force Medical Treatment Facilities (MTF). CONUS-based MTFs have specific wartime missions as described in the following paragraph.

3.1.1. Continuity of Care. All CONUS-based medical units will continue providing medical services for remaining active duty personnel, dependents, and other non-active duty beneficiaries, unless their MAJCOM informs them otherwise. Under wartime conditions, when the local base or military MTF cannot provide medical care to beneficiaries, the MTF will arrange for care through the civilian sector under existing agreements and as designated through the TRICARE Lead Agent for their respective region.

3.2. Functions of the Department of Veterans Affairs (DVA). The VA health care system is the primary backup to the DoD in time of war or national emergency. The VA and DoD must jointly plan and establish procedures to implement contingency operations. Air Force MTFs identify wartime medical support requirements and areas where they may need VA support. Specifically, they identify any requirements that may be beyond the MTF capability and then inform the nearest VA medical facility. The designated VA facility and MTF jointly plan for using available VA resources during wartime or emergency situations. Local plans and agreements and Memoranda of Understanding (MOU) document VA support. Plans, including MOUs should be reviewed by MAJCOMs.

3.3. Reserve Component Concept of Operations:

3.3.1. RC personnel play a significant role in wartime medical operations, providing the majority of support for aeromedical evacuation missions, staffing medical treatment units in the theater of operations, and supporting CONUS medical augmentation requirements.

3.3.2. After active duty and RC personnel deploy, the following personnel will replace or augment medical staff at CONUS MTFs:

3.3.2.1. RC unit personnel.

3.3.2.2. Individual Mobilization Augmentees (IMA).

3.3.2.3. Pre-trained Individual Manpower (PIM), consisting of the Individual Ready Reserve, Retired Reserve, Standby Reserve, and Retired Regular.

3.3.3. Air Force wartime requirements are the basis of medical IMA Ready Reserve authorizations. Assignments in the IMA Program are authorized positions managed by HQ ARPC/SG, Denver, CO, with training attachments at active duty Air Force units.

3.3.4. In peacetime, IMA reservists complete medical readiness training and peacetime mission support at their active duty unit.

3.3.5. During wartime contingencies, CONUS MTFs employ medical IMAs as replacements for MTF personnel who have deployed. They will mobilize to any base that requires their specialty. Although they can deploy, medical IMAs normally are not assigned to a specific deployment position before a contingency.

3.3.6. Each MTF or unit designated to receive personnel replacements should include information in the unit contingency plan that outlines reception, training, and support requirements for these personnel. The MTF needs to develop the MCRP with their RC input and then provide a copy of the plan to each unit. The RC unit needs to incorporate the contingency plan into the Unit Mission Briefing.

3.3.7. Active duty medical planners will address required post-mobilization medical support for non-collocated reserve organizations in the CONUS Mission Support Plan. Include collocated organizational medical support in local host-nation or host/tenant support agreements.

3.4. Functions of the National Disaster Medical System (NDMS).

3.4.1. The NDMS is an integrated federal, state, local and private sector medical response system for medical support during wartime or major U.S. domestic disasters. NDMS provides DoD with medical care resources from the civilian sector to backup the VA and DoD medical contingency arrangement.

3.4.2. Specific Air Force MTFs are designated as NDMS Federal Coordinating Centers (FCCs). They will:

3.4.2.1. Develop, maintain, and exercise an NDMS operations and patient reception plan for the assigned area in conjunction with other federal, state and local agencies; offices of emergency services; media; and other agencies, as required. Include in each exercise a review of local procedures for Military Patient Administration Teams (MPAT) and verify supporting military unit MPATs are staffed and trained, as applicable.

3.4.2.2. Establish and maintain MOUs with local hospitals for participation in NDMS, as well as with those providing support as detailed in the MCRP. MOUs identify the types of support and the conditions under which that support becomes available.

3.4.2.3. Participate in continuing education programs with state, county, and community offices of emergency services and other health care organizations.

3.4.2.4. Plan and implement at least one annual NDMS area exercise to test the metropolitan area plan.

3.4.2.5. Identify NDMS resource requirements, to include training and exercises, through the existing MTF budget process.

3.4.2.6. Provide the MAJCOM/SG NDMS representative with the name, rank, address, office symbol, duty title, DSN, e-mail address, commercial telephone and FAX numbers of the individual assigned to FCC responsibilities. Provide an information copy to HQ USAF/SGXR.

3.4.2.7. Report minimum and maximum bed numbers for each NDMS participating hospital as required by HQ USAF/SGXR. Request of bed information is licensed under RCS: HAF-SGX (AR) 8602, *Medical Report for Emergencies, Disasters and Contingencies* (MEDRED-C). During emergency situations, the report is designated emergency status and precedence code C-1, Continue under emergency conditions, Priority. Transmit during MINIMIZE, as necessary.

3.4.3. HQ USAF/SGXR and ARPC/SG will develop and fund periodic training for medical MPAT members at their assigned facility. Obtain documentation describing the MPAT concept, including training information, through HQ USAF/SGXR, 1360 Air Force Pentagon, Washington, DC 20330-1360. (Reference Annex R of the MCRP).

3.4.4. ANG medical and aeromedical evacuation units coordinate all exercise and contingency response activities involving NDMS with ANG/SG. These ANG units must prepare an exercise plan and submit it for approval before participating with NDMS in an exercise. Coordinate all contingency support requirements involving ANG medical resources with ANG/SG.

Chapter 4

ASSESSMENTS/EVALUATION AND MEDICAL REPORTING

4.1. Assessment Objective. Mission readiness is based upon how well a unit is organized, trained, and equipped. The assessment process centers on three vital steps: 1) review of medical readiness indicators; 2) validation of data related to indicators through multiple activities; and 3) feedback through the SG, Wing, NAF, MAJCOM, AFIA, and Air Staff to plan for and correct identified indicator deficiencies.

4.2. Medical Readiness Indicators. Mission readiness is based upon three major criteria, which are AFMS capability to organize, train and equip (OTE). Standards are established for some of the indicators using readiness percentages outlined in AFI 10-201. Other indicators are assigned yes/no responses to determine why a unit is not mission capable. All indicators will be defined in the Medical Readiness Decision Support System (MRDSS), pending approval of the Configuration Control Board. Indicators are used to assist higher headquarters determine probable causes of deficiencies.

4.2.1. Indicators used to determine how well units organize for mission accomplishment may include, but are not limited to the following:

4.2.1.1. MCRP date of last review.

4.2.1.2. Date of current Designed Operational Capability (DOC) Statement.

4.2.1.3. Gaining Unit Plans.

4.2.1.4. .Level of experience of MR staff.

4.2.1.5. Medical readiness shortfalls.

4.2.1.6. MR Office Staff attended MRPC and/or Contingency Wartime Planner's Course (CWPC).

4.2.1.7. Percent of personnel assigned by UTC.

4.2.1.8. Percent of personnel available by UTC.

4.2.1.9. All deployment requirements completed IAW AFI 10-403.

4.2.1.10. Unit CC reviewed OTE status.

4.2.1.11. MRDSS updated monthly.

NOTE: Bold items are considered critical indicators and are used to determine color codes for MRDSS.

4.2.2. Indicators used to determine how well unit's train for mission accomplishment may include, but are not limited to the following:

4.2.2.1. Organization conducted mission-specific contingency support training.

4.2.2.2. Didactic training and contingency support training containing mission specific information.

4.2.2.3. Training was tailored to meet current DOC statement requirements.

4.2.2.4. Sufficient numbers of personnel, as defined by HQ USAF/SGXR, were trained to maintain mission ready status.

4.2.2.5. Personnel were trained IAW minimum requirements outlined in this instruction and other applicable directives.

4.2.2.6. Initial and sustainment training were conducted as preparat ion for deployment platform mission accomplishment as required in DoDI 1322.24, AFI 10-204 and AFI 10-403.

4.2.2.7. Training currency was routinely monitored and evaluated.

4.2.2.8. Deployable personnel were trained on DEPMEDS/WRM materiels/assemblages to the greatest extent possible.

4.2.2.9. 4.2.2.9.Training programs were realistic and allowed familiarization, to the greatest extent possible, with DEPMEDS/WRM materiels/assemblages.

4.2.2.10. 4.2.2.10.Results of training were conveyed to the MRSF members monthly with formal discussions conducted, at a minimum every other month at the scheduled MRSF.

4.2.2.11. 4.2.2.11.Training shortfalls were identified through MRDSS.

4.2.2.12. 4.2.2.12.Formalized programs to train contingency response teams (peacetime and wartime) consistent with mission support requirements were institutionalized.

4.2.2.13. 4.2.2.13.AFSC specific training was included in the development of unit training programs.

4.2.2.14. Unit annual training schedules/plans were submitted to the MAJCOM readiness offices by the base level medical planner after approval of the MRSF. AFRC units follow guidance as stated in AFRESI 10-204.

4.2.2.15. Provisions for implementing make up dates for missed training were in place for personnel with training schedule conflicts. See Team Chief Responsibilities, **5.10.2.**.

4.2.2.16. Training was documented as specified by applicable directives.

4.2.2.17. 882nd Training Course Outlines were utilized during Continuing Medical Readiness Training.

4.2.2.18. Training equipment was available for applicable contingency training.

4.2.3. WRM and deployable asset indicators used to determine how well units equip for mission accomplishment may include, but are not limited to the following:

4.2.3.1. WRM Stock Status Report.

4.2.3.1.1. Percentage indicated by project code

4.2.3.2. Date of inventory.

4.2.3.2.1. Accuracy of inventory.

4.2.3.2.2. Critical shortfalls identified.

4.2.3.3. Outdated medications.

4.2.3.3.1. Identify which are outdated now.

4.2.3.3.2. Indicate those to be outdated within 90 days.

4.2.3.4. Medical equipment maintenance reports are available.

4.2.3.5. WRM vehicle information is available as to functionality of vehicle and shortfalls.

4.2.3.6. Sourced lead units (command and control element) are responsible for coordination with MAJCOMs and theater medical planners to assure/document readiness of prepositioned assets at least biennially. Findings shall be identified in after action reports forwarded to MAJCOMs, theater planners and Air Staff for action/follow up as appropriate. Funding requirements shall be identified by sourced lead units to their MAJCOMs.

4.2.3.6.1. Contingency Hospital (CONHOSP) or Air Force Theater Hospital (AFTH).

4.2.3.6.2. Transportable Blood Transshipment Center (TBTC).

4.2.3.7. Other prepositioned assets, i.e., Air Transportable Hospitals (ATHs), Hospital Surgical Expansion Packages (HSEPs), and Aeromedical Staging Facilities (ASFs).

4.2.3.8. Equipment availability to perform Mission Essential Tasks to include non-UTC specific requirements.

4.3. Medical Readiness Validators. Medical readiness validators are those processes that substantiate unit effectiveness in organizing, training and equipping as reported through MRDSS. Major validators include but are not limited to: Operational Readiness Inspections; Operational Readiness Exercises; After Action Reports; Joint Universal Lessons Learned System (JULLS); Audits; Exercises; Functional Management Reviews; Special Management Reviews; Situation Reports; MEDRED-Cs; NATO TacEvals; AFIA/SG inspections; Air Force ***Remedial Action Program (RAP);*** and Staff Assistance Visits. MAJCOMs will provide primary oversight to the verification and validation of their respective unit's readiness status.

4.4. Operational Readiness Inspections (ORI), Operational Readiness Exercises (ORE), and North Atlantic Treaty Organization Tactical Evaluations (NATO TacEvals). ORIs, OREs, and NATO TacEvals are performance-based evaluations of unit capability to conduct missions in a simulated wartime scenario. Generally, UTCs identified in DOC Statements are tasked to deploy, employ, and in some instances redeploy as they would in support of a major theater war. MAJCOMs, NAFs, or other higher headquarters agencies direct ORIs. OREs are Wing directed. NATO schedules TacEvals.

4.4.1. Minimum Common Core Criteria (CCC) for ORIs are indicated in **attachment 5**. Comprehensive medical readiness training programs, developed IAW **chapter 5** this instruction, should include these CCC. These CCC, along with other core competencies identified in the AFSC specific database, MEDS, MRT, and other applicable directives specifying critical wartime skills (such as AFRCI 41-102), are items that may be evaluated during the ORI/ORE. This provides an indication of how well personnel have been trained to perform their assigned missions.

4.4.2. MAJCOMs may expand the list of CCC that may be inspected during ORIs.

4.5. Exercise Objective. Specified exercises and evaluations of unit readiness plans ensure that units can provide the required medical response for peacetime and wartime contingencies. Periodic exercises train medical personnel, enable them to practice documented procedures, and verify medical unit readiness. They also enhance cooperation with civilian hospitals and agencies.

4.6. Exercise Requirements. Medical and Aeromedical Evacuation (AE) exercises will be realistic and contingency based. Medical personnel will comply with non-medical exercises required IAW AFI

32-4001 (including mass casualty), DoDI 1322.24, and other deployment guidance, i.e., AFI 10-401 and AFI 10-403 to fulfill medical exercise requirements whenever possible. Medical exercise evaluation team representatives will participate in wing/base exercise planning to assure medical training requirements are met. Exercise scenarios involving the simulated movement of medical resources to CONUS or OCONUS locations should incorporate pre-deployment, deployment, employment, re-deployment, and post deployment phases. All operational phases do not have to occur in one particular exercise. When planning required exercises, units should integrate with wing activities as defined objectives and scenarios may fulfill requirements for multiple types of exercises, i.e., the Attack Response Exercise may incorporate a mass casualty scenario, which meets one requirement for the MCRP exercise. Lack of wing exercises does not preclude medical exercise requirements. The following sections describe the minimum exercise requirements. All exercise and training requirements in this instruction will be completed on a twelve month cycle unless stated otherwise (For minimum exercise requirements, see **attachment 6**).

4.6.1. Medical Contingency Response Plan (MCRP) Exercises. **(Not applicable to RC)**

4.6.1.1. Medical participants in wing/unit exercises will be scenario dependent. That is, not all personnel assigned to the medical/AE unit may be required to support the requirements of the event. Determination of the extent of resources required to respond shall be made at the Medical Control Center or its equivalent.

4.6.1.2. All UTCs identified in the unit DOC Statement will be exercised, at a minimum, on an annual basis.

4.6.1.3. All MCRP annexes shall be exercised at least annually.

4.6.1.4. All military/civilian MOUs/MOAs will be reviewed at least annually. When possible, exercises should be coordinated and executed to assess mutual support arrangements and/or support.

4.6.1.5. Units can choose to exercise portions of the wartime mission separately, for example, blood donor center (BDC) mission, as determined by the medical unit commander. Scenarios must provide practical application of didactic training and application of AFSC specific training requirements.

4.6.2. Recall Plans. Unit commanders will develop pyramid recall procedures to recall personnel. Recall plans should describe the methods and procedures the unit uses to recall personnel to their duty station from their local residence or other non-duty locations. Recall exercises demonstrate the ability of the medical unit to provide contingency support and shall be conducted IAW the Base/Wing exercise schedule. Personnel subject to recall will be dependent upon the event scenario. Additional recall exercises may be conducted at the Commander's discretion.

4.6.3. Alternate Medical Facility Exercise. Must be conducted biennially and include review of procedures for moving patients to other medical facilities. Team Chiefs, Executive Staff of units that can't use their alternate medical facility for exercise purposes will conduct a walk-through of the facility, inventory "real-world" supply kits, and review unit plans and procedures annually. MAJCOMs can set additional guidelines that ensure exercise program objectives are met (not applicable to RC).

4.6.4. NDMS Exercise. USAF NDMS FCCs must conduct an annual exercise with civilian hospitals that participate in the NDMS program. Planners will ensure that exercise scenarios closely resemble wartime conditions or domestic disaster situations.

4.6.5. Deployment Processing or Exercise. Units with a deployment mission fulfill deployment program requirements in accordance with AFI 10-403 and applicable base deployment program procedures.

4.6.6. The following must occur at the frequencies indicated for those units tasked with equipment set responsibility:

4.6.6.1. Air Transportable Clinics and Air Transportable Hospitals must be exercised at least annually, by assigned personnel, to include marshaling, staging, and assemblage set-up (includes checking operability of all equipment, including generators, heaters, lighting systems and appropriate fuel sources, as well as performing a complete inventory of equipment/supplies with special emphasis on dated item assessment and re-sterilization check). Documented evidence of real-world deployment satisfies this requirement. ATC assets will be inventoried and exercised by the Squadron Medical Element (SME) with which it will deploy, if collocated.

4.6.6.2. Aeromedical Evacuation Liaison Team, Aeromedical Evacuation Coordination Center, and Mobile Aeromedical Staging Facility assemblages must be exercised and inventoried at least annually, by assigned personnel, to include marshaling, staging, and assemblage set-up (includes checking operability of all equipment, including generators, heaters, lighting systems and appropriate fuel sources, as well as performing a complete inventory of equipment/supplies). Documented evidence of real-world deployment satisfies this requirement.

4.6.6.3. Aeromedical evacuation crews, decontamination teams, patient retrieval teams, and other non-ATH/ATC teams that operate with equipment sets must conduct like exercises and inventories. Documented evidence of real-world deployment satisfies this requirement.

4.7. Exercise Scenarios. Scenarios that may satisfy a mass casualty exercise requirement include the following:

4.7.1. Nuclear event.

4.7.2. Chemical event.

4.7.3. Biological event.

4.7.4. Conventional warfare.

4.7.5. Terrorist act.

4.7.6. Aircraft accident.

4.7.7. Natural disaster.

4.7.8. Civil disturbance.

4.8. Exercise Criteria. AFMS units will meet the following exercise criteria:

4.8.1. The organization met contingency exercise requirements (number, type, and frequency) as specified by applicable directives.

4.8.2. All UTCs assigned on the unit DOC statement were exercised at least annually (when possible and practical, UTCs assigned to units for warehousing only, will be exercised by personnel tasked against that equipment. Inventory of the equipment will be conducted IAW established agreements).

4.8.3. Exercise objectives were accomplished and requirements monitored.

4.8.4. Concerns were referred to the MRSF or designated oversight activity. (MRDSS indicator system, if applicable)

4.8.5. Exercise scenarios were realistic and exercise reports documented effectiveness of planning guidance, training programs, and operational responses.

4.8.6. Scenarios promoted both AFSC competency and non-AFSC specific training accomplishment.

4.8.7. Performance assessments were accomplished by trained evaluators of pre/trans/post contingency responses.

4.8.8. Post-exercise or incident critiques were conducted by appropriate team chiefs (peacetime and wartime designees) and address training deficiencies, areas for improvement, and response plan improvements.

4.8.9. Identified areas of concern are briefed to the MRSF and assigned OPRs to develop corrective action plans with estimated completion dates.

4.8.10. MRSF reviewed and approved specific corrective actions.

4.8.11. Open items for corrective action are tracked through the MRSF/executive committee until resolved, tested and closed.

4.8.12. Unit commanders, through the MRSF or Executive Management Committee (EMC), elevated corrective actions that go beyond corrective capabilities of the local unit.

4.9. Integration of Medical/Aeromedical Evacuation Operations into Air Base Operations.

4.9.1. Intra-Theater and Inter-theater Interfacing. Exercise scenarios should include intra-theater and inter-theater AE interface. Participants should be briefed on the exercise scenario, theater CONOPS, rules of engagement, and supporting base plans. Seamless patient movement through the medical infrastructure should occur.

4.9.2. Conduct of AE Operations. The primary focus should be on understanding the medical/AE CONOPS, evolution of medical/AE operational capabilities, patient preparation for evacuation, realistic and safe flight line operations, establishment of logistical support, establishment of communications, and development of base operational support (to include weapons support).

4.9.3. Procedures for patient tracking from first point of regulation through echelons of care must be established and exercised, to the extent possible.

4.10. AFMS Involvement in an Annual Major Field Training Exercise. DoDI 1322.24 establishes a requirement for all Services to participate in an annual Joint Service exercise involving all echelons of care, to include AE and other ancillary support. Air Force Medical Service (AFMS) participation will be determined by higher headquarters and appropriate units tasked IAW requirements identified during Joint exercise planning.

4.11. Required Documentation:

4.11.1. Critique Procedures. Team chiefs, medical unit Exercise Evaluation Team (EET) members, and Medical Readiness Staff Function members will conduct a post-exercise or incident critique. They will use this critique to provide cross-feed among participants, identify problems not annotated

by the base EET, identify training deficiencies, and modify existing plans and training programs where necessary.

4.11.2. Post-Exercise or Incident Summary. This comprehensive summary report focuses on unit involvement in an exercise or actual incident. Following the event, units will use the summary to provide a forum for verbal and written inputs from team chiefs, EET members, and other observers. The MR Office consolidates inputs in the comprehensive summary report and uses it to brief the MRSF. This report should include the following information, as applicable:

4.11.2.1. Participants.

4.11.2.2. Scenario.

4.11.2.3. Number and types of casualties.

4.11.2.4. Objectives.

4.11.2.5. Achievement of objectives.

4.11.2.6. Identification of deficiencies.

4.11.2.7. Observations.

4.11.2.8. Recommended corrective actions for MRSF review.

4.11.2.9. Recommended changes to base and medical unit plans and checklists for MRSF review.

4.11.3. Summary Report Review. Post-exercise or incident reports will be reviewed by the MRSF and attached to the minutes. The MRSF will review and approve any recommended changes in local plans or any specific corrective actions as well as insure significant concerns, such as apparent training deficiencies, are reflected in Indicator System reporting through MRDSS.

4.12. Deployed Medical Reporting. HQ USAF and respective MAJCOMs have assigned operational reporting requirements of each medical treatment facility. HQ USAF and MAJCOMs use these reports to make operational decisions on medical support of forces during emergency operations to include operational readiness status, unit availability, and patient care activities.

4.12.1. The MTF or unit commander will ensure the Medical Report for Emergencies, Disasters and Contingencies (MEDRED-C) (RCS: HAF-SGX (AR) 8602) is submitted IAW procedures outlined in AFM 10-206. Liberal use of the REMARKS section is encouraged. This is one method of ensuring the MAJCOM receives valuable data regarding unit operations in the AOR.

4.12.2. In a deployed environment, casualty reporting as outlined in AFI 36-3002 and AFI 10-215 will be accomplished by the Personnel Support for Contingency Operations (PERSCO) team or the attached MPF. Close coordination must be maintained between the Mortuary Affairs Officer, medical service personnel, and the PERSCO team.

4.12.3. Disease and Non-Battle Injury Data (DNBI) data will be compiled and reported by PH with assistance from the MTF administration section. The report format, frequency, and distribution will be determined by the AFFOR Surgeon. Computerized data collection and analysis can be done with the Medical Surveillance Theater Program or Desert Care II software. Use of the program is recommended. Reportable events are reported IAW AFI 48-105.

4.13. After-Action Report, RCS: HAF-SGX (AR) 7901:

4.13.1. Medical treatment facilities and units, including RC, must submit an after-action report to their respective MAJCOM/SG 30 days after completing deployment of War Reserve Materiel (WRM) or personnel UTCs, or after participating in a higher headquarters or JCS sponsored exercise. **Note: Prior to drafting AAR, verify classification level with the classification authority for the exercise/ deployment/ operation.** Medical units that support an actual contingency or contingency exercise submit an after-action report within 30 days after they resume normal operations at their home station, or as directed by higher headquarters. Contingencies include the following:

4.13.1.1. National emergency.

4.13.1.2. Natural disaster.

4.13.1.3. Armed conflict.

4.13.1.4. NDMS activation.

4.13.1.5. Any other response directed by HQ USAF, JCS, or the National Command Authorities.

4.13.2. MAJCOM/SG OPRs provide the format for the after-action report (unless otherwise directed by higher authority, i.e., JCS directed use of Joint Universal Lessons Learned System (JULLS)). Format for AFRC units are described in AFRCI 10-204. This report is designated emergency status and precedence code C-2, Continue reporting, Normal. Transmit during MINIMIZE if necessary. MAJCOM OPRs should mail information copies of the report as follows:

4.13.2.1. AFMIC/MA-OPS, Fort Detrick, Frederick, MD 21702-5004.

4.13.2.2. AFMLO/FOCW/FOM, Fort Detrick, Frederick, MD 21702-5006.

4.13.2.3. HQ USAF/SGXR, 170 Luke Avenue Suite 400, Bolling AFB, DC 20332-5113.

4.13.2.4. 384 TRS/XXDB, 882 TRG, 925 Missile Road, Sheppard AFB, TX 76311-2245.

4.13.2.5. USAFSAM/PH, 2602 West Gate Road, Brooks AFB, TX 78235-5001.

4.13.3. Provide a copy of the report to the air component command headquarters OPR if the exercise or operation occurred in their theater. This includes, as applicable: US Air Forces Atlantic (AFLANT), US Central Command Air Forces (CENTAF), US Pacific Air Forces (PACAF), US Southern Command Air Forces (SOUTHAF) or United States Air Forces in Europe (USAFE).

4.13.4. AFRC medical units will submit the after-action report to: HQ AFRC/SGX, 155 Second Street, Robins AFB GA 31098-1635.

4.13.5. ANG medical units will submit the after-action report to their gaining MAJCOM and ANG/SGX, 3500 Fetchet Avenue, Andrews AFB, MD 20762.

4.13.6. Additional AAR guidance may be found in AFI 10-204.

Chapter 5

INITIAL AND SUSTAINMENT TRAINING

5.1. Purpose and Objectives. Medical readiness training (MRT) encompasses the entire spectrum of peacetime and wartime training and exercises, using unit contingency plans (peacetime and wartime) as its foundation. Emerging national and military strategies are driving forces behind the need for all AFMS personnel to be fully trained for deployment in support of a Major Theater War, Small Scale Contingency, or Military/Humanitarian Operation Other Than War. Many of these events are conducted in austere environments and may require deployment of personnel who are not assigned against UTC positions. Additionally, deployed forces may consist of Reserve Component (RC) and/or active duty (AD) personnel. Critical training tasks are identified in the AFSC specific training database that must serve as a catalyst for training program development. The 384th TRS, 925 Missile Road, Sheppard AFB, TX 76311-2251 has developed a Computer Based Instruction program that may be downloaded from (http://882web.spd.aetc.af.mil/384/readiness/mrtf.htm). Emerging training requirements identified through Force Protection initiatives and Agile Combat Support must become an integral part of any initial and sustainment training programs. Specific requirements will be identified through appropriate message transmission.

5.2. AFSC Specific Sustainment Training. The AFSC specific training database is the primary guide for medical specialty specific medical readiness training. Units must consider AFSC specific training requirements when developing their annual medical readiness training plan and schedule to ensure that every opportunity to conduct training is captured and planned for appropriately.

5.2.1. The unit MRT program should be organized according to the unit's deployment mission and individual AFSCs. To organize the program, units should adhere to the following procedures:

5.2.1.1. Identify the unit's deployed mission and echelon of care to determine the level of training for personnel. Personnel must know their deployment mission.

5.2.1.2. Identify all AFSCs assigned to the facility.

5.2.1.3. The Commander will formally appoint a functional training manager as OPR for each AFSC. These individuals will have the following responsibilities:

5.2.1.3.1. Review training requirements for their respective AFSC.

5.2.1.3.2. Distinguish Common Core Criteria (CCC) satisfied during daily practice, routine inservices, exercises, etc.

5.2.1.3.3. Coordinate with MR Office and Medical Education and Training to determine methodology and timeline for completion of AFSC specific CCC sustainment training.

5.2.1.3.4. Maintain a continuity folder on their AFSC training program that records, at a minimum who receives training, what training has been completed, and when was it completed (all must be verifiable).

5.2.1.3.5. Actively participate in tracking and reporting of UTC sustainment training as reported through MRDSS.

5.2.1.3.6. MR Office interfaces with AFSC managers, Education and Training, Career Field Managers, and other applicable offices/personnel to fully implement the AFSC specific training program.

NOTE: Units should plan training events to maximize training opportunities and document training using available automated resources. Individual training reports should be provided to members upon permanent change of station or deployments.

5.2.2. Corps specific sustainment training requirements are embedded within the AFSC specific database as well as the training matrix in Attachment 3 and should be referred to when developing the annual training plan and schedule.

5.2.3. Hazardous Material (HAZMAT) training for medical response personnel will be provided by base civil engineering IAW AFI 32-4002, Hazardous Material Emergency Planning and Response Program. The medical readiness office will maintain training documentation.

5.2.4. All BEE Flights, whether or not they have a formal BEE NBC Team (FFGL1) tasking, will conduct joint training with their CE Readiness Flight counterparts, modeled after the FFGL1 CONOPS. Training will be conducted at least annually to ensure BEE and CE Readiness personnel operate effectively as a team for NBC contingency responses and support to operations in NBC environments.

5.3. Integration of SMRTS (Active Duty), MRT (ANG) and MEDS (AFRC) Training Tracking Programs. Active and Reserve Component forces have developed similar tracking/reporting systems for training. Anticipated merger of these databases will ensure standardization of tracking training throughout the AFMS. During the interim period, units should contact their respective MAJCOM for source of AFSC specific training requirements. Units will incorporate AFSC specific sustainment training into annual training plan development. Documentation of training will occur through the use of existing tracking systems. Upon consolidation of systems, revised policy regarding use of the standardized training and reporting database will be transmitted to Reserve and active units.

5.4. Medical Readiness Field Training:

5.4.1. All military medical personnel assigned to MTFs and AE units must participate in medical readiness field training. MAJCOM/SGs may authorize exemptions, if appropriate, but they must be prepared to fully justify such exemptions to higher headquarters.

5.4.2. DoDI 1322.24 requires at least five days of medical readiness training annually. At a minimum, field CMRT must be conducted in an austere environment over a full two-day period in a realistic manner. A sample field-training schedule may be found in **attachment 7**. The remaining three days of required CMRT training, as directed in DoDI 1322.24, may be conducted through training scenarios determined by the unit commander. Exercises and training must be scheduled in a manner that permits activities to continue throughout daytime and nighttime operations incorporating appropriate work/rest cycles established by the unit commander. CMRT cadre schedules should be arranged in shifts to facilitate 24-hour operations. Safety should not be jeopardized in any phase (pre-deployment, trans-deployment, deployment and post-deployment) of field CMRT. Ambulance support should be available, during field training, to support emergencies. The training/exercise agenda should maximize opportunities to conduct AFSC-specific training and completion of those training requirements identified in the AFMS Sustainment Training Matrix (**attachment 3**).

5.4.3. Site selection and shelter assemblage (temper tent to general-purpose small, medium, or large tentage) field sanitation and hygiene, and perimeter security are integral components of field CMRT.

5.4.4. All military personnel supervised by or assigned to the DBMS or AES commander (MTFs, AE units, SMEs, and other medical personnel assigned to non-medical UTCs) must complete the requirements listed in this chapter. MAJCOMs may grant a six-month waiver to units who are transitioning from a spring to fall CMRT cycle. **Training is annual, current only for 12 months.**

5.4.4.1. Submit requests for organizational exemptions to the MAJCOM/SG or equivalent. Approving authority will review and renew requests annually.

5.4.4.2. Personnel must complete all applicable medical readiness training requirements within six months of qualification in their AFSC per DoDI 1322.24.

5.4.4.3. UTC specific training must emphasize proficiency of skills in operating deployable assemblages.

5.4.5. The RC Medical Field Training Program is based on a four-year training cycle. RC medical unit personnel fulfill their medical field training through completion of a tour at their medical readiness training sites. ANG medical units attend the program at Phelps-Collins CRTC, Alpena, Michigan, and AFRC at Sheppard AFB, Texas.

5.4.5.1. RC headquarters may designate other applicable training sites (i.e., Patriot MedStar). The RC Medical Field Training Program is based on a four year training cycle. AE units are required to complete AECOT or Joint Readiness Training Center (JRTC) on a four-year cycle.

5.4.5.2. Further guidance for AFRC is found in AFRCI 10-204. AFRC priority for attendance at the MRTS is as follows:

5.4.5.2.1. Priority 1 – ATH/ACTH.

5.4.5.2.2. Priority 2 – 50 & 100 Bed ASTS's.

5.4.5.2.3. Priority 3 – 250 bed ASTS's.

5.4.5.2.4. Priority 4 – Generation units, All others.

5.4.5.3. The AE unit training must focus on establishing and maintaining command, control, and communications over aeromedical evacuation assets, and on maintaining mission-ready crews. Training emphasizes the integration of all UTCs to create a functional AE system.

5.5. Continuing Medical Readiness Training (CMRT) Requirements: Continuing Medical Readiness Training is all readiness training that occurs in an individual's military career. It includes initial training and all additional sustainment training.

5.5.1. All enlisted personnel receive initial training, through the Basic Medical Readiness Course (BMRC) in conjunction with their AFSC-specific courses at Sheppard or USAFSAM. Officers receive initial training by attending the Medical Readiness Indoctrination Course, in conjunction with Commissioned Officer Training (COT). Officers that do not receive this initial training must be trained at the unit level within six months of their assignment.

5.5.1.1. Includes practical and didactic training, with an orientation to all CMRT core topics.

5.5.1.2. Standardizes entry-level MRT received by all medical personnel.

5.5.1.3. Establishes the baseline for CMRT.

5.5.2. The primary focus of unit CMRT must be mission-specific training and exercises, supported by specialty-specific training and education.

5.5.2.1. Core topics include:

5.5.2.1.1. Command, Control, and Communications, and Intelligence

5.5.2.1.2. Laws of Armed Conflict and Code of Conduct

5.5.2.1.3. USAF Medical Service Mission

5.5.2.1.4. Geneva Conventions

5.5.2.1.5. Nuclear, Biological, & Chemical Warfare

5.5.2.1.6. Casualty Management

NOTE: Computer Based Instruction for the core topics is available through the Worldwide Web from the 384 TRS/XXDC. Adapt lesson plans and other briefing materials according to local training needs. Videotapes and other audiovisual aids may be used.

5.5.3. Units that deploy to a Contingency Hospital (CONHOSP) or Air Force Theater Hospital (AFTH) should conduct training that stresses familiarization with CONHOSP/AFTH operations bearing in mind that some OPLAN tasked CONHOSP/AFTHs exist in relatively austere environments. As the AFTH is re-engineered, the CONOPS will change, as will training requirements. Members must review the theater hospital allowance standard for their respective work stations and be familiar with (to the extent possible) the equipment/supplies with which they will be working upon deployment.

5.5.4. Units that have multiple missions must train and exercise to the strictest unit requirement (deployment versus in-place, or generation, mission). The medical unit commander at a site with more than one mission will divide unit training to prepare for each designated mission.

5.5.5. Units that have a deployment mission will train primary deployment personnel and, if available, alternates on that mission. Personnel not on deployment will train for in-place generation, peacetime missions, and as time permits, potential deployment tasking.

5.5.6. Interns, residents, and personnel in fellowship training participate in medical readiness training in accordance with MAJCOM guidelines. These personnel are not included in SORTS reporting.

5.5.7. Health Professions Scholarship Program (HPSP) personnel must participate in unit-level CMRT as available during their 45-day annual tour of duty at an Air Force MTF. This includes participating with other MTF personnel in medical readiness training and exercises scheduled during their tour as their duty schedule permits. First-year physician residents and residents in deferred status are exempt from CMRT requirements.

5.5.8. CMRT is recommended for all Chaplain Service personnel assigned to MTFs or Chaplain Readiness Teams with a deployment tasking. The base Senior Chaplain ensures that the Chaplain Readiness Officer coordinates with the medical unit MRO/MRNCO/MRM to arrange for Chaplain Service personnel to participate in CMRT. MAJCOMs and Field Operating Agencies (FOAs) can provide additional guidelines.

5.5.9. MAJCOMs must provide supporting (or gained) units, including the RC, with a description of any theater-specific training requirements not listed here.

5.5.10. SMEs/Geographically Separated Unit medical personnel and non-medical personnel assigned to medical elements will complete the requirements in this chapter as well as specialized training in support of unique medical missions. The host MTF/MDS will monitor the CMRT status of all medical personnel assigned to their base. The CMRT status of medical personnel assigned to non-medical UTCs will be forwarded monthly to the unit's assigned MAJCOM.

5.5.11. Non-medical personnel (non-medical AFSC) assigned to medical units in support of the health care mission are required to complete Self/Aid/Buddy Care as opposed to the wound management course of instruction.

5.6. SORTS T-Level Measurement Training Requirements. The SORTS report is an indicator of a unit's ability to accomplish its DOC assigned mission. AFI 10-201, *Status of Resources and Training System,* and RC-specific supplements contain specific policy on SORTS reporting and supplements containing specific MAJCOM/DRU/RC policies on SORTS reporting.

5.6.1. To be considered trained for SORTS reporting purposes, individuals must maintain currency in the specific portions of the CMRT program described in the following paragraphs.

5.6.2. Newly assigned unit personnel have an "in training" status for up to six months after signing into a unit. They can be considered current for SORTS purposes during this time, but must complete unit mission-specific training requirements within 6-months of qualification in their AFSC. This training must begin when personnel in-process through the unit MR Office.

5.6.3. Use the following elements of CMRT to determine the SORTS Training Category C-level:

5.6.3.1. Mission-Specific Contingency Support Training. Include MCRP exercises and training. Deployments and MAJCOM evaluations during Operational Readiness Inspections are also included.

5.6.3.2. Didactic Training. Incorporate mission-specific information in this training. Complete the following CMRT core topics annually for AD and RC:

5.6.3.2.1. Command, Control, and Communications, and Intelligence.

5.6.3.2.2. Laws of Armed Conflict and Code of Conduct.

5.6.3.2.3. USAF Medical Service Mission.

5.6.3.2.4. Geneva Conventions.

5.6.3.2.5. Nuclear, Biological, & Chemical Warfare.

5.6.3.2.6. Casualty Management.

NOTE: MAJCOMs can set requirements for completion of additional CMRT core topics.

5.6.3.3. Individual Survive to Operate Skills. Include at least CBWDT, CBWD Qualification Training, and Alarm Signals. The MAJCOM can specify other topics or skills necessary to function in high-threat areas.

5.6.4. RC supplements to Air Force policy documents contain additional guidelines for determining the SORTS Training Category C-level for RC units.

5.6.5. The following are not used to determine the SORTS Training Category C-level:

5.6.5.1. Combat Arms Training.

5.6.5.2. Combat Medicine Training.

5.6.5.3. Corps specific MRT.

5.7. Training Documentation:

5.7.1. Document CMRT on any locally developed tracking form, on AF Form 1098 (Special Task Certification and Recurring Training), or using an automated system. Transfer applicable records of previous training to the local tracking system. AFRC units will use the Medical Electronic Database System (MEDS).

5.7.1.1. The ANG Medical Readiness Office personnel will document training on an overprinted AF Form 1320 or 1320a, Training Chart, or computer printout. Software for the Medical Readiness Training System (MRTS), which contains the Individual Medical Readiness Training Summary, is available from ANG/SG.

5.7.2. Maintain documentation for the current and previous calendar year for validation of training currency.

5.7.3. If automated data support is not available, maintain a separate training folder for each member of the organization.

5.7.4. Credentialed provider's commander certified sustainment training data (for the AF utilize commander certification of annual CMRT training) must be recorded in the Centralized Credentials Quality Assurance System IAW DoDI 1322.24.

5.7.5. Current medical readiness training data must accompany each AFMS member upon permanent change of station or transfer to another AFMS and be presented to the MR Office during unit inprocessing.

5.7.5.1. All personnel departing the unit will be provided a letter, AF Form 1098, or computer summary indicating all training completed, and as applicable, a deployment folder. These documents will be signed by the appropriate unit medical readiness office staff to verify training completed and to provide necessary training documentation for the gaining unit. Training documentation verifies that supervisors, trainers, and/or task certifiers have validated the minimum competency and performance levels were met.

5.7.6. For the RC, maintain the following additional documentation:

5.7.6.1. Copy of Cardiopulmonary Resuscitation (CPR) certification card if training is not accomplished by the medical unit.

5.7.6.2. Waiver letters.

5.7.6.3. Copies of certification as a health care practitioner or instruction in Advanced Cardiac Life Support (ACLS) training and Advanced Trauma Life Support (ATLS) training.

5.7.6.4. Copies of state or national certification as an Emergency Medical Technician (EMT) or EMT instructor.

5.7.6.5. Instructor credentials for any other military or civilian course providing training applicable to medical readiness.

5.7.6.6. AF form 522 (for deployment personnel).

5.7.6.7. AF Form 1098 or a computer summary of medical readiness training from their previous unit of assignment.

5.7.6.8. Certificates for completion of any military or civilian courses providing medical readiness training.

5.8. CMRT Equivalency Credit: Formal Courses, Special Training Events, and Deployments:

5.8.1. Personnel can also be given CMRT credit for full participation as an instructor of these courses. The medical commander can grant credit for *portions* of CMRT for completion of (or instruction of) any of the following formal courses:

5.8.1.1. Medical Readiness Indoctrination Course (MRIC).

5.8.1.2. Basic Medical Readiness Course (BMRC).

5.8.1.3. All Medical Red Flag (MRF) courses.

5.8.1.4. CMRT sponsored by ANG at the Alpena Combat Readiness Training Center (CRTC).

5.8.1.5. USAFSAM entry level AFSC awarding courses which include MRT.

5.8.1.6. Combat Casualty Care Course (C4).

5.8.1.7. Combat Casualty Management Course (C4A).

5.8.1.8. Battlefield Nursing (BFN).

5.8.1.9. Combat Advanced Trauma Life Support (sponsored by the Navy).

5.8.1.10. Medical Management of Chemical Casualties Course (M2C3).

5.8.1.11. Medical Effects of Nuclear Weapons (MENW) Course.

5.8.1.12. Aeromedical Evacuation Contingency Operations Training (AECOT)

5.8.1.13. Aeromedical Technician Course.

5.8.1.14. Flight Nurse Course.

5.8.1.15. Completion of training and testing for the US Army Expert Field Medical Badge (EFMB).

5.8.1.16. Joint Readiness Training Center (JRTC) exercises (Ft Polk, LA).

5.8.1.17. Public Health Contingency Operations Course.

5.8.1.18. AFRC Medical Readiness Field Training (MRFT).

NOTE: Completing these courses does not excuse personnel from participating in mission-specific unit training.

5.8.2. Credit can also be granted for participation in actual operational deployments, a major JCS exercise, or a MAJCOM exercise. Participation is defined as active performance of AFSC-related medical duties for the majority of the exercise or deployment. Commanders can grant personnel a

twelve month exemption from mission-specific CMRT if the exercise or deployment was relevant to the unit DOC missions.

5.8.3. Unit commanders may request credit waivers of field training from their respective MAJCOM for involvement in OREs/ORIs, as long as requirements identified in paragraph **5.4.**, this instruction, are satisfied. Credit for RC forces may be granted for up to four years.

5.8.4. The MR Office verifies completion of any of these courses, special training events, or deployments and documents the CMRT credit granted on the individual training record.

5.8.5. If a course does not have "field training" as a component/objective of the course, credit will not be given for having completed "field training" for that year.

5.8.6. Guidelines and specific information on attendance of formal courses is provided in Air Force Catalog (AFCAT) 36-2223, USAF Formal Schools.

5.9. Unit Mission Briefing. The purpose of this annual didactic training is to ensure personnel have a working knowledge of the roles and responsibilities of the medical unit in both peacetime and wartime. Provide this briefing also as orientation for newly assigned medical unit personnel. The training will include:

5.9.1. Medical wartime mission. Outline the wartime concept of operations as described in the unit MCRP, tasking OPLANS, and appropriate Base Support Plans (BSPs).

5.9.2. Medical peacetime mission. Provide an overview of MCRP operations.

5.9.3. Other medical missions or support. Provide an overview of any other medical missions or support required in MAJCOM or installation plans, including specific items identified in base-level programs such as the Disaster Preparedness Program (see AFI 32-4001) and the Air Base Operability Program (see AFI 10-212).

5.10. Unit Disaster and UTC Team Training:

5.10.1. Each team identified in the MCRP must receive training every twelve months. Each team chief will develop an annual team training schedule for each calendar year, which will be submitted to the MRSF for review. **(Not applicable to RC)**

5.10.2. The team chief will send documentation of training to the MRO/MRNCO/MRM. This documentation will include: dates of training, subjects covered, attendees, and signature of the instructor. In addition, team chiefs will ensure make up training is accomplished and documented for personnel that missed scheduled training.

5.10.3. If RC forces are assigned to augment AD teams, they must be included in the development of the annual team training schedule and participate accordingly, depending on available RC resourcing. Designated training will be coordinated between the team chiefs, medical readiness office, and reserve component units to which the members are assigned.

5.11. Chemical-Biological Warfare Defense (CBWD) Training (CBWDT) and Individual CBWD Task Qualification Training (TQT):

5.11.1. CBWDT. AFI 32-4001 identifies individuals who require CBWDT. Individuals who received CBWD training, including ground crew ensemble and mask confidence training (MCT),

through formal MRT within the preceding 12 months require only CBWD refresher training through their base program instead of the initial course at base-level. Formal training courses which suffice for the initial and refresher CBWD base-level course include: BMRC, MRIC, C4, and some USAF-SAM AFSC-awarding courses (when mask confidence training is included). The MR Office documents CBWD training received by medical unit personnel through formal MRT courses and informs the base Civil Engineering Readiness Flight office regarding same. (See AFI 32-4001 for additional information on CBWDT and MCT.)

5.11.2. Individual CBWD Qualification Training: This involves performance of AFSC-related tasks in a chemical-biological environment. MAJCOMs will identify specific tasks, standards, and procedures for conducting training within their command. Training can be conducted as part of team training and exercises.

5.11.3. CBWDT and Individual CBWD Task Qualification Training will be conducted IAW MAJCOM/CEX guidance.

5.12. Combat Arms Training. Personnel identified in AFPD 16-8, Arming of Aircrew, Mobility, and Overseas Personnel shall complete training as required. Failure to qualify does not remove an individual from deployment or PCS assignment overseas. AFI 36-2226, *Combat Arms Training and Maintenance (CATM) Program*, governs combat arms training.

5.12.1. Additional guidance includes:

5.12.1.1. Personnel currently assigned overseas are trained according to guidelines of MAJCOM, as directed by the theater commander-in-chief (CINC). Personnel assigned to certain PACAF locations (such as Hawaii and Alaska) are exempt from this training, as specified through HQ PACAF.

5.12.1.2. All personnel assigned to a primary deployment position must complete firearms training. Qualification is not mandatory, except as outlined in paragraph **5.12.2.**

5.12.2. Weapons and qualification requirements are as follows:

5.12.2.1. Minimum weapons requirements are identified at **attachment 4**. However, the theater CINC may provide additional requirements. These will be specified in the operation's Execute Order.

5.12.2.2. At least one person per UTC must qualify for each required weapon, as outlined at attachment 4. Units will coordinate with their local Combat Arms Training and Maintenance (CATM) personnel for additional weapons qualifications requirements for personnel on alternate deployment UTC positions. Failure to qualify does not automatically remove an individual from deployment status. All medical personnel who qualify can be issued a weapon.

5.12.3. Document training on AF Form 522, *USAF Ground Weapons Training Data*, as prescribed in AFI 36-2226. AFRC units also document training in the MEDS database.

5.12.4. The medical unit commander will ensure that medical personnel who receive weapons training also receive training that emphasizes the special status obligation of medical personnel under the Geneva Conventions.

5.12.5. MAJCOM/SGs can grant individual waivers to medical personnel based on religious beliefs or deep personal convictions against participating in firearms training, however personnel granted

waivers will be briefed on potential implications to their own and their patients' safety. Letters for exemption to small arms qualification should be routed through respective unit commanders prior to submission to MAJCOM/SG.

5.12.6. Unit or MTF responsible for the majority of a UTC tasking is responsible for ensuring weapons are available to support the entire UTC requirement IAW AFPD 16-8, Arming of Aircrew, Mobility, and Overseas Personnel. Minimum weapons requirements for deploying medical personnel are listed in Attachment 4. Purchase of the weapons is not required if a base agency agrees to support the requirement, as documented in an MOU.

5.13. Combat Casualty Care Course (C4) and C4 Administrative (C4A) Training:

5.13.1. The target groups for C4 (or C4A) training for AF medical personnel include: physicians, dentists, nurse practitioners, nurse anesthetists, and BSC providers (including physician assistants and optometrists).

5.13.2. US Air Force participation depends on HQ AETC/SG funding and on allocation of training quotas to MAJCOMs.

5.13.3. There is no recurring training requirement to C4 or C4A. See AFCAT 36-2223 for additional information.

5.14. MRT for Dental Corps (DC) Officers. USAF Dental Service Readiness Training Guidelines, published by HQ USAF/SGD, describes additional readiness training for dental officers.

5.14.1. MAJCOM-FOA/SGDs will use these guidelines to develop dental MRT requirements. Consider the unique requirements of individual installations and theaters supported.

5.14.2. Medical units will develop training programs locally to meet stated objectives and requirements. Obtain the MRSF and MAJCOM/SGD approval of the medical unit program.

5.14.2.1. The senior dental officer certifies training. Document training on AF Form 1098, on a locally developed form, or through an automated tracking system.

5.15. MRT Requirements for the Air Force Theater Hospital and Air Transportable Hospital Executive Management Team . Members of the CONHOSP/AFTH and ATH Executive Management Team should attend C4, C4A, or Medical Red Flag training as determined by the supported command training requirements.

5.16. MRT for RC Members During Annual Tour. This section applies to individuals or units not scheduled to attend medical readiness training at the MRTS at Sheppard AFB, TX, or the MRTS at Alpena, MI.

5.16.1. Active duty host MTFs must involve RC members in all aspects of MRT, to include CMRT, to the greatest extent possible. This is especially critical during annual tours of IMAs, units, and incremental member tours.

5.16.2. The primary focus of RC training in medical treatment facilities is AFSC-specific or sustainment training. Sustainment training is:

5.16.2.1. Regular, recurring training necessary to maintain medical skills of a fully qualified individual to adequately perform patient care duties required by the individual's job in peacetime and wartime.

5.16.2.2. An RC program and concept.

5.16.3. The MTF must provide MRT during these annual tours to ensure that RC members are familiar with the professional and administrative issues relevant to their wartime roles.

5.16.4. RC units scheduled to complete their annual tour at an MTF must provide the host MTF with their annual training plan, indicating support needed from the MTF. Training requirements will be mutually agreed to and negotiated in advance.

5.16.5. The host MTF retains responsibility for certain training not provided through RC training programs.

5.16.5.1. The host MTF will provide RC medical professionals core AFSC specific sustainment training. Since these programs are ongoing, it may be difficult to accomplish a full program during a two week annual tour.

5.16.5.2. The host will provide RC members a signed letter, memo, or computer generated report to certify and document training, including dates of training, subjects covered, and personnel in attendance. Each RC member provides this documentation to their unit training manager to facilitate appropriate updates in personal training folders and CCQAS.

5.16.5.3. Training outlined in paragraph **5.16.** is required each time a RC member or unit performs an annual tour at an active duty MTF.

5.17. IMA Training Program Management:

5.17.1. HQ ARPC/SG will:

5.17.1.1. Coordinate and implement HQ USAF/SG medical readiness training objectives and policies as they apply to medical IMA Reservists.

5.17.1.2. Provide regulatory policy on medical readiness training programs.

5.17.1.3. Assist Air Force MTFs who encounter problems scheduling IMA Reservists for CMRT.

5.17.1.4. Provide recommendations related to this instruction to HQ USAF/SGXR.

5.17.2. The Unit of Attachment fulfills the following responsibilities:

5.17.2.1. The Air Force MTF Commander will:

5.17.2.1.1. Ensure that IMA Reservists receive required medical readiness training.

5.17.2.1.2. Ensure IMA Reservists receive information on training requirements, the training schedule, and other required information. Provide this information when a tasking is established in planning documents.

5.17.2.1.3. Assign an Air Force Reserve Liaison Officer/NCO.

5.17.2.2. The Air Force Reserve Liaison Officer/NCO will:

5.17.2.2.1. Ensure that IMA Reservists receive a minimum of 60 days notice of scheduled medical readiness training.

5.17.2.2.2. In coordination with the MRO, monitor the program to ensure readiness training is completed and appropriately documented.

5.17.2.2.3. Maintain documentation for on a two-year cycle for validation of training currency.

5.17.2.2.4. If automated data support is not available, maintain a separate training folder for each member of the organization.

5.17.2.2.5. Notify HQ ARPC/SG of any IMA Reservist who fails to comply with training requirements.

5.17.2.3. The Medical Readiness Officer will:

5.17.2.3.1. Obtain a list of attached IMAs at least annually from the unit Air Force Reserve Liaison Officer.

5.17.2.3.2. Forward the NBC training statistics annually for all attached IMAs to ARPC/SGE.

5.17.2.3.3. Assist the Air Force Reserve Liaison Officer/NCO in all IMA documentation.

5.17.3. The IMA Reservist will:

5.17.3.1. Request the annual medical readiness training schedule from the Air Force MTF to which attached.

5.17.3.2. Complete scheduled training as required, or arranges for alternate training agreeable to the MTF.

5.17.3.3. Request orders using AF Form 1289, **Application for Active Duty training**, if attendance will be in Annual Training or Special Tour status. HQ ARPC/SG must receive the request at least 45 days in advance of scheduled training.

5.18. IMA Exercises and Training:

5.18.1. All medical IMA Reservists assigned to Category B authorized positions must complete CMRT.

5.18.2. Medical Reservists in Category E and Category H Reinforcement Designee training status are not required to complete CMRT, but are encouraged to do so on a voluntary basis.

5.18.3. All personnel must complete CMRT (as outlined in chapter 5) at least every 2-calendar years. HQ ARPC/SG must approve deviations from the 2-year requirement.

5.19. Methods of Attendance. Medical IMA Reservists can complete the training requirements included in this chapter in one of the following capacities:

5.19.1. Annual Training (AT).

5.19.2. Inactive Duty Training (IDT). IDT status can include either a pay or non-pay (retirement points only) status.

5.19.3. Special Tour--Reserve Personnel Appropriation (RPA) Mandays. Ensure that requests for orders (AF Form 1289) are received by HQ ARPC/SG at least 45 days in advance of scheduled training for AT and Special Tour status. Special Tour status is recommended for completing medical readiness training requirements.

5.20. Unified Command, MAJCOM, Numbered Air Force, Air Staff, ANG Readiness Center Staff, and Joint Staff Medical Plans Officers/NCOs. It is recommended that medical planners in these positions will attend the Joint Medical Planner's Course and Contingency Wartime Planner's Course within their first year of assignment (as training billets permit). Fellows assigned to readiness billets at these locations should attend the same courses. This will be coordinated by their gaining agency.

CHARLES H. ROADMAN, II, Lt General, USAF, MC
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

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AFPD 10-2, *Air Force Readiness Program,* March 1, 1997

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AFI 32-4001, *Disaster Preparedness Planning and Operations*, May 1, 1998

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AFI 32-4002, *Hazardous Material Emergency Planning and Response Program,* December 1, 1997

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AFPD 41-1, *Health Care Programs and Resources,* April 15, 1994

AFI 44-105, *Air Force Blood Program,* October 1, 1997

AFCAT 21-209, *Ground Munitions,* March 1, 1998

AFCAT 36-2223, *USAF Formal Schools,* July 1, 1997

AFM 23-110, Volume V, *Air Force Medical Materiel Management System-General*

U.S. Air Force Survival, Recovery and Reconstitution (SRR) Plan 55

(S)United States Air Force Counterproliferation Master Plan, Dec 97

Abbreviations and Acronyms

ABO—Air Base Operability

ACLS—Advanced Cardiac Life Support

AC—Active Component

ACC—Air Combat Command, Langley AFB, VA

AD—Active Duty

AE—Aeromedical Evacuation

AECC—Aeromedical Evacuation Coordination Center

AECOT—Aeromedical Evacuation Contingency Operations Training

AELT—Aeromedical Evacuation Liaison Team

AETC—Air Education and Training Command, Randolph AFB, TX

AFB—Air Force Base

AFCAT—Air Force Catalog

AFI—Air Force Instruction

AFLANT—US Air Forces Atlantic

AFM—Air Force Manual

AFMAN—Air Force Manual

AFMIC—Armed Forces Medical Intelligence Center, Ft. Detrick MD

AFMLO—Air Force Medical Logistics Office, Ft. Detrick MD

AFMOA—Air Force Medical Operating Agency, Bolling AFB DC

AFMS—Air Force Medical Service

AFPD—Air Force Policy Directive

AFRC—Air Force Reserve Command, Robins AFB, GA

AFSC—Air Force Specialty Code

AFSOC—Air Force Special Operations Command, Hurlburt Fld, FL

AFSPC—Air Force Space Command, Peterson AFB, CO

AFTH—Air Force Theater Hospital

AMC—Air Mobility Command, Scott AFB, IL

ANG/SG—Air National Guard Air Surgeon

ANGRC—Air National Guard Readiness Center, Andrews AFB MD

RC—Air Reserve Components

ARE—Attack Response Exercise

ARPC—Air Reserve Personnel Center, Denver, CO

ASF—Aeromedical Staging Facility

AT—Annual Training

ATC—Air Transportable Clinic

ATH—Air Transportable Hospital

ATLS—Advanced Trauma Life Support

BDC—Blood Donor Center

BEE—Bioenvironmental Engineer

BFN—Battlefield Nursing

BSC—Biomedical Sciences Corps

CAT—Combat Arms Training

CATM—Combat Arms Training and Maintenance

CBTA—Chemical-Biological Threat Area

CBWD—Chemical-Biological Warfare Defense

CBWDT—Chemical-Biological Warfare Defense Training

CCA—Contamination Control Area

CCC—Common Core Criteria

CCQAS—Centralized Credentials Quality Assurance System

CENTAF—US Central Command Air Forces

CHAMPUS—Civilian Health and Medical Program of the Uniformed Services

CHATH—Chemically Hardened Air Transportable Hospital

CINC—Commander-in-Chief

CME—Continuing Medical Education

CMRT—Continuing Medical Readiness Training

CONOPS—Concept of Operations

CONUS—Continental United States

CPR—Cardiopulmonary Resuscitation

CRH—Casualty Receiving Hospital

CRT—Crisis Response Team

CRTC—Combat Readiness Training Center

CTLS—Combat Trauma Life Support

C3—Command, Control, Communications

C4—Combat Casualty Care Course

C4A—Combat Casualty Management Course

DC—Dental corps

DOC—Designed Operational Capability

DoD—Department of Defense

DOP—Deployment Operating Procedure

DP—Disaster Preparedness

DVA—Department of Veterans Affairs

ECD—Estimated Completion Date

EFMB—US Army Expert Field Medical Badge

EMT—Emergency Medical Technician

EMC—Executive Management Committee

FCC—Federal Coordinating Center

FMC—Field Medical Card

FOA—Field Operating Agency

HAF—Headquarters Air Force

HQ—Headquarters

HQ ACC—Headquarters Air Combat Command, Langley AFB VA

HQ AETC—Headquarters Air Education and Training Command, Randolph AFB TX

HQ AFMC—Headquarters Air Force Materiel Command, Wright Patterson AFB OH

HQ AFMPC—Headquarters Air Force Military Personnel Center, Randolph AFB TX

HQ AFRC—Headquarters Air Force Reserve Command, Robins AFB GA

HQ AFSOC—Headquarters Air Force Special Operations Command, Hurlburt Fld FL

HQ AFSPC—Headquarters Air Force Space Command, Peterson AFB, CO

HQ AMC—Headquarters Air Mobility Command, Scott AFB IL

HQ ARPC—Headquarters Air Reserve Personnel Center, Denver CO

HQ PACAF—Headquarters Pacific Air Forces, Hickam AFB HI

HQ USAF—Headquarters United States Air Force, Washington DC and Bolling AFB DC

HQ USAFE—Headquarters United States Air Forces in Europe, Ramstein AB, GE

HQ USAF/REM—Medical Liaison to Commander, Air Force Reserve Command

HPSOP—Health Professions Scholarship Program

HSEP—Hospital Surgical Expansion Package

IDMT—Independent Duty Medical Technician

IDT—Inactive Duty Training

IMA—Individual Mobilization Augmentee

JCS—Joint Chiefs of Staff

LOAC—Law of Armed Conflict

MAJCOM—Major Command

MARE—Major Accident Response Exercise

MASF—Mobile Aeromedical Staging Facility

MC—Medical corps

MCC—Medical Control Center

MCT—Mask Confidence Training

MCRP—Medical Contingency Response Plan

MEDRED-C—Medical Report for Emergencies, Disasters, and Contingencies

MEDS—Medical Electronic Data System

MENW—Medical Effects of Nuclear Weapons

MINIMIZE—A procedure used during periods of crisis or other abnormal periods to reduce the volume of record and long distance telephone traffic ordinarily transmitted electrically. MINIMIZE applies to all users of Department of Defense (DoD) communications systems, including originators of card and tape traffic. When MINIMIZE is imposed, users of DoD electrical communications must determine that: 1) the information to be sent is required to avoid a seriously detrimental impact on mission accomplishment or safety of life; and 2) electrical transmission is the only way to get the information to the addressee in sufficient time to accomplish the purpose. (Allied Communications Publication 122, US Supplement 1)

MIO—Medical Intelligence Officer

MOU—Memorandum of Understanding

MPA—Military Personnel Appropriation

MPAT—Military Patient Administration Team

MRDSS—Medical Readiness Decision Support System

MRF—Medical Red Flag

MRIC—Medical Readiness Indoctrination Course

MRM—Medical Readiness Manager

MRNCO—Medical Readiness Non-Commissioned Officer

MRO—Medical Readiness Officer

MRPC—Medical Readiness Planner's Course

MRSF—Medical Readiness-Staff Function

MRT—Medical Readiness Training

MRTS—Medical Readiness Training Site

MRPC—Medical Readiness Planning Course

MSC—Medical Service Corps

MTF—Medical Treatment Facility

M2C3—Medical Management of Chemical Casualties Course

NBC—Nuclear, Biological, Chemical

NDMS—National Disaster Medical System

NEO—Non-combatant Evacuation Operation

NGB/SG—National Guard Bureau Air Surgeon

OCONUS—Outside CONUS

OPLAN—Operation Plan

OPR—Office of Primary Responsibility

PACAF—US Pacific Air Forces

PERSCO—Personnel Support for Contingency Operations

PH—Public Health

PHO—Public Health Officer

PIM—Pre-trained Individual Manpower

RCS—Report Control Symbol

RPA—Reserve Personnel Appropriation

SEI—Special Experience Identifier

SMRTS—Standardized Medical Readiness Training System

SOFME—Special Operations Forces Medical Element

SORTS—Status of Resources and Training System

SOUTHAF—US Southern Command Air Forces

SRR—Survival, Recovery and Reconstitution

TBTC—Transportable Blood Transshipment Center

USAFE—United States Air Forces in Europe

USAFSAM—US Air Force School of Aerospace Medicine, Brooks AFB TX

UTC—Unit Type Code

VA—Veterans Affairs

WAR-MED PSO—Wartime Medical Planning System Office

WCD—Work Center Description

WRM—War Reserve Materiel

WMP—War and Mobilization Plan

Attachment 2

FORMAT FOR THE MEDICAL CONTINGENCY RESPONSE PLAN

1. THE BASIC PLAN.

a. References. List references and dates in six subsections as follows:

Air Force Policy and Guidance (e.g., AFPDs, AFIs, AFP, AFMANs, etc.).

MAJCOM Policy and Guidance

Wing Publications

Plans

Maps, Charts, and Grid Maps (the base and surrounding area, as applicable).

Other references.

b. Contributing Organizations. Include all units and organizations (military and civilian) which can support the medical facility. Describe the support provided by these entities and means of activating support agreements, if applicable. Any organization referenced in the plan should coordinate prior to publication. You can employ RC medical units only when they are performing unit training duty. RC aeromedical evacuation units can provide support if it doesn't interfere with their unit flight obligations.

c. Execution. Include at least the following paragraphs:

(1) Describe the conditions under which the MCRP will be executed, who directs the execution, and who executes the plan.

(2) Special instructions. State which parts of the plan are required reading.

(3) A descriptive statement for each major team and a corresponding reference annex. The descriptive statement should tell who is responsible for preparing and maintaining each annex. Indicate responsibilities for sub-teams as an appendix to the appropriate annex.

2. THE ANNEXES. Each annex provides definitive information as to how, where, when, and who performs a particular function. Team compositions (peacetime disaster teams and Unit Type Codes) must indicate Air Force Specialty Code (AFSC) supporting their missions. Support each annex with checklists, designed to serve as a quick reference, chronological list of actions required in any given situation. Team chiefs prepare and maintain the checklists. You need not include checklists in the MCRP, but they must be readily available to each team chief, medical control center, and emergency treatment area. List supporting checklists (by subject or title) within the applicable annex. If not published in a unit training plan, include an abbreviated list of training requirements and where a more comprehensive listing can be found (i.e., team training binder, AFSC specific training database, AFI 41-106 training matrix, etc.) Include the following annexes, as applicable:

a. Annex A--General Instructions. Include information applicable to all medical personnel, regardless of team assignment. Discuss the following:

(1) Recall procedures.

(2) Space allocation.

(3) Triage categories and color-coding system. The Triage Officer examines all casualties and categorizes them according to a color-coded system. When using color-coding systems to represent triage categories, coordinate with local emergency response agencies to prevent confusion during actual emergencies or joint military/civilian exercises. The following CATEGORIES and colors are generally used for standardization:

MINIMAL - Green.

IMMEDIATE - Red.

DELAYED - Yellow.

EXPECTANT - Blue.

NOTE: Civilian medical organizations do not recognize EXPECTANT as a peacetime triage category.

(4) A description and diagram of the patient flow within the facility (peacetime and wartime).

(5) Command, Control, Communications (C3). Indicate the location of the MCC and describe command and control components, and communication systems. List actions required to restore communications if they break down.

(6) Outline base mission support with clear delineation between peacetime and wartime procedures. Do not duplicate guidance contained in the Base Support Plan, but ensure vital information is readily available to applicable personnel.

(7) At a minimum, address the following: Generation mission support (medical/dental patient records screening, ensure currency of DD Form 1480-a, immunizations, CW/BW antidote instructions, medical intelligence instructions); Battle Staff support; Disaster Control Group support

b. Annex B--Medical Facility Commander/Medical Control Center (MCC). Address at least those responsibilities listed in chapter 1 and briefly outline the chain of command to ensure continuity if the commander is unavailable during peacetime and wartime scenarios. Outline contingency operations procedures, responsibilities, and communications resources. Clearly delineate peacetime and wartime contingencies. Additionally address medical reporting procedures.

c. Annex C--Patient Dispersion. Address anticipated patient population in wartime and peacetime, projected changes in availability of hospital services during contingencies and the impact on patient dispersion. If routine care will not be curtailed, describe prioritization of care. Also describe aeromedical evacuation policies and guidelines, as applicable for patient dispersion Included would be a description of aeromedical staging activities and communications between the Aeromedical Staging Facility, Mobile Aeromedical Staging Facility, and MTF, as applicable.

d. Annex D--Casualty Management. Describe casualty management for each respective team/work center, to include casualty flow within the facility. Include facility expansion procedures (if applicable) to include manpower and staffing requirements and utilization. Facility usage, WRM inventory, maintenance and set-up should be addressed in Annex G, Medical Logistics. Include the following appendices and tabs:

Appendix 1 - Aerospace Medicine

Tab 1 - Field Treatment Team

Appendix 2 - Clinical Teams

Tab 1 - Minimal Team

Tab 2 - Delayed Team

Tab 3 - Immediate Team

Tab 4 - Radiology Team

Tab 5 - Laboratory Team

Tab 6 - Pharmacy Team

Tab 7 - Surgery Team

Tab 8 - Nursing Services

Tab 9 - Mental Health

e. Annex E--Public Health Team. Outline support to the base and MTF in providing:

Communicable and vectorborne disease surveillance, prevention, control, and reporting

Field hygiene and sanitation surveillance

Site selection consultation

Food safety

Medical intelligence and health threat assessment

Deployment health threat education

Pre and post deployment health screening management

Casualty decontamination

f. Annex F--Bioenvironmental Engineering (BEE) Team. Outline support to the base and MTF in providing:

Service as a member of the wing Survival Recovery Center (SRC).

Evaluations or assessments of environmental and occupational health hazards and recommended actions for control of these hazards.

Monitoring of base water supply to ensure potability, vulnerability, and survivability.

Monitoring, evaluation, and direction for control of chemical, biological, and radiological hazards.

Assistance in selecting base and unit shelters.

Service as a member of the Wing NBC Cell.

Service as a member of the Initial Response Force performing health risk assessment.

Provide NBC detection guidance to the Public Health Team, as needed.

Assistance to the CE Readiness Flight in developing an NBC detector deployment plan and conducting NBC detection.

g. Annex G--Medical Logistics Team. Wartime planning shall include the identification of WRM management and maintenance requirements, description of generation mission support, and defining pro-

cedures for emergency requisition of equipment and/or supplies. Peacetime planning shall outline logistics support such as procedures for emergency requisition, facility management, biomedical equipment repair/maintenance program and the following Appendices:

Appendix 1 - Develop fire evacuation/protection plan and list associated references.

Appendix 2 - Describe facility expansion procedures and floor plan, as applicable. Address WRM inventory, set-up and maintenance, space allocation and manpower requirements.

h. Annex H--Manpower Team. Indicate the team responsibilities in supporting the overall medical response. Address, as a minimum, patient movement, facility evacuation support, and procedures for requesting additional manpower support. This team can include medical unit personnel not directly involved in patient care, collocated RC medical personnel present for duty, volunteer personnel, base personnel, outpatients awaiting discharge or transportation, and any other personnel available.

i. Annex I--Crisis Response Team (CRT). Use this optional annex in addition to or in place of the "Mental Health Team," which is normally an appendix to Annex D. The primary responsibility of the CRT is to provide mental health services to victims and families on site and within the MTF during and post-disaster. Discuss team composition (for example, mental health officers, technicians, chaplains, public affairs officer) and responsibilities.

j. Annex J--Facilities Management Team. Describe facility management activities in ensuring: maintenance and repair support; availability of required utilities; facility security; and maintenance or repair of communications assets.

k. Annex K--Food Service Team. Consider this function (particularly overseas), even though food service may not be a formally authorized function.

l. Annex L--Patient Administration Team. Outline responsibilities relevant to patient administration functions during peacetime and wartime contingencies. Do not replicate day-to-day operational functions addressed by other directives. Focus should be on activities directly related to contingency operations.

m. Annex M--Civilian Disturbances. Discuss medical operations during a civil disturbance.

n. Annex N--Bomb and Terrorist Threats. Discuss medical operations if the facility is faced with a bomb threat or other terrorist act.

o. Annex O--Transportation. Address requirements for medical transportation, materiel handling, and personnel support. Primary emphasis on wartime requirements are on movement, marshalling and staging of all medical resources to fulfill mission requirements, sheltering of vehicles (as applicable), and reference to appropriate base support plans. Peacetime considerations are relocation of supplies, equipment, and personnel to the alternate medical facility, as well as patient transport considerations.

p. Annex P--Alternate Facility. Outline procedures for rapid transition from the medical facility to an alternate facility. This annex must include the following:

A floor plan outlining space allotment for the various patient care activities.

Food service agreements.

Plan for movement of equipment and supplies, including linen.

Reference to local support agreements and implementation policy. Do not include the actual agreements in the MCRP, but indicate their location in the medical facility.

All communication requirements and arrangements to meet requirements.

Hazardous materiel procedures.

q. Annex Q--Shelter Operations. According to installation shelter program guidelines, medical units will identify shelters for protecting or housing personnel. (See AFMAN 32-4005, *Personnel Protection.*) Outline procedures for movement to the shelter. Indicate the type or extent of medical care that will be available in the shelter. Planning is based on the types of disasters most likely to occur in the particular area. Keep the formal shelter plan in the MCC and in the designated shelter. Delineate which activities are applicable to peacetime or wartime, only.

r. Annex R--NDMS Peacetime Operations. MTFs designated as NDMS Federal Coordinating Centers prepare this annex. The MCRP can reference separately developed NDMS operations or patient reception plans that describe NDMS operations and are used instead of this annex. MTFs not designated as FCCs can use this annex to describe potential involvement with NDMS operations, if applicable.

s. Annex S--Deployment. Describe the unit's deployment mission(s) and address all deployment requirements, to include force reception plan. Refer to Annex A and G for additional deployment processing guidance.

t. Annex T--Disaster Response and Recovery. Use this annex to describe response and recovery procedures for "worst case" scenarios, such as a catastrophic natural disaster directly affecting your installation and facility. Address scenarios in which a disaster renders the base and medical facility partially or totally inoperable. Work with base Civil Engineering Readiness Flight staff in developing this annex. Discuss protective measures (personnel and resources), phases of response, and recovery procedures. Include comprehensive procedures for evacuation or dispersion of patients, medical personnel, and resources. Recovery procedures should address at least the following:

Reconstitution plans for medical personnel and medical resources

Re-establishing a medical capability.

Establishing an insect and rodent control capability.

Health care for active duty and non-active duty beneficiaries.

u. Annex U--Blood Program. Describe procedures, personnel requirements, and facilities necessary to provide whole blood and blood derivatives for casualty treatment. Planning should be consistent with AFI 44-105, Air Force Blood Program, and address situations that require activation of the blood program. Specify provisions for activating the blood donor center, blood transshipment center, or other assigned blood program missions to include procedures for exercise and resupply. Indicate agreements with local agencies for obtaining necessary supplies

v. Annex V--Aeromedical Evacuation. Use this annex to describe the AE interface with base response activities, as applicable.

w. Annex W--TRICARE. Use this annex to address the role of TRICARE during contingency operations.

z. Annex Z--Distribution. See paragraph 2.3.1.

Attachment 3

AFMS SUSTAINMENT TRAINING MATRIX

All requirements are annual unless otherwise indicated. Msn = Mission Specific, Freq = Frequency, P = Performance, K = Knowledge, I = Initial, S = Sustainment

Requirement	**All AFSC[1]**	**AFSC Spec[2]**	**Msn[3]**	**P**	**K**	**I**	**S**
Orientation							
Critical Incident Debriefing	**x**				**x**	**x**	**x**
AFSC Mission Specific Training	**x**				**x**	**x**	**x**
Medical Plans and Readiness Orientation (specific annex) (Include the readiness mission of the facility/unit)	**x**				**x**	**x**	**x**
Communications Security [COMSEC] and Operations Security [OPSEC], Computer Security	**x**				**x**	**x**	**x**
Medical Intelligence	**x**				**x**	**x**	**x**
HAZCOM Awareness (OSHA vs. Military Unique Requirements)	**x**		**x**		**x**	**x**	**x**
Waste Management	**x**				**x**	**x**	**x**
Occupational Health and Safety (include: hearing protection, needle sticks, xray exposure, lifting/ body mechanics)	**x**	**x**	**x**		**x**	**x**	**x**
Infection Control (include: hand washing, blood spills, alert 'read signs', reporting)	**x**				**x**	**x**	**x**
Interactions with Civilian Activities (include NGO)	**x**				**x**	**x**	**x**
Echelons of Care	**x**				**x**	**x**	**x**
MHSS Orientation: JV 2010,MRSP,WMP,AFMS Strat Plan, AE Strat Plan, Telemed Strat Plan, Mirror Force Strat Plan, Major Theater War, Complex Contingency Operations, Mirror Force, Defense Planning Guidance, Joint Service Interoperability ,ATH/AE CONOPS,NDMS	**x**				**x**	**x**	**x**
Terrorism	**x**				**x**	**x**	**x**
Threat and Future Battlefield Environment	**x**				**x**	**x**	**x**
Alarm Conditions	**x**				**x**	**x**	**x**
Cardiopulmonary Resuscitation [CPR][4]	**x**			**x**	**x**	**x**	**x**
Disaster Response					**x**	**x**	**x**
Wound Management (Trauma and Burn)		**x**			**x**	**x**	**x**
Self-Aid Buddy Care [SABC] i.g. MSCs, 4A0's etc.	**x**	**x**		**x**		**x**	**x**
Triage	**x**				**x**	**x**	**x**
Combat Stress	**x**	**x**			**x**	**x**	**x**
Ambulance Operation		**x**		**x**		**x**	**x**
Patient Administration		**x**			**x**	**x**	**x**
Medical Effects of Nuclear, Biological, Chemical [Warfare]	**x**	**x**		**x**	**x**	**x**	**x**
Radio Communication and Etiquette	**x**				**x**	**x**	**x**

Requirement	All AFSC[1]	AFSC Spec[2]	Msn[3]	P	K	I	S
Command, Control, Communications, Computers, Intelligence [C4I] (include STU-III)	x				x	x	x
Litter Bearing	x				x	x	x
Radio Communications Procedures			x		x	x	x
Shelter Management	x				x	x	x
Camouflage, concealment and deception	x			x	x	x	x
Vehicle Operations		x	x	x		x	x
Hazardous Cargo Certification		x	x		x	x	x
Equipment Palletizing and Mobilization		x	x	x		x	x
Marshaling		x	x	x		x	x
Non-Mission Specific							
Base Operations Support [LG;TRANS;COMM]			x		x	x	x
Biological/Chemical Warfare Defense [BW/CW]			x	x	x	x	x
Re-deployment/Re-employment (Bug-Out)			x		x		x
Cargo Prep/Palletization		x	x	x	x	x	x
Cargo Preparation			x	x	x	x	x
Deployment Procedures/Execution (personal readiness; legal brief: Wills/POAs; Family Services; Survivor Benefits, items/clothes)			x	x		x	x
Deployment Process	x			x	x	x	x
Explosive Ordnance Recon/Management [EOR]	x			x	x	x	x
Field Sanitation and Hygiene	x				x	x	x
Geneva Conventions [to include mgmt of EPWs] , Law of Armed Conflict [LOAC]	x				x	x	x
Medical Reporting (include SORTS, MEDREDCs, SITREPS)		x	x		x	x	x
Mission Oriented Protective Posture [MOPP]	x			x	x	x	x
Patient Movement Items [PMI] CONOPS/Management			x		x	x	x
Resource Protection and Site Security	x				x	x	x
Site Selection			x		x	x	x
Vehicle Operations		x	x	x		x	x
Medical Mission Specific					x	x	x
AE Systems Patient Preparation (include in CCAT)		x			x	x	x
Blackout Procedures			x		x	x	x
Blood-Programs (i.e., Blood Donor Sites, TBTC)			x	x	x	x	x
Command, Control, Communications, Computers, Intelligence [C4I] (include STU-III)			x		x	x	x
Field Medical Logistics			x		x	x	x
Food Inspection		x			x	x	x
Medical Logistics Management		x			x	x	x
Night Operations			x	x	x	x	x
Patient Regulation Procedures		x	x		x	x	x
Set-up/Operation of Mission Equipment and Assemblages			x	x		x	x
Small Arms Training			x	x		x	x
Standard Performance Criteria for Medical UTCs			x				

Requirement	All AFSC[1]	AFSC Spec[2]	Msn[3]	P	K	I	S
Unique Theater Requirements (include: Local Nationals as Patients, Local Culture Orientation, Foreign Patient Processing, SOFA, NGO)			x	x	x	x	
Unit Mission Training/CONOPS			x		x	x	x
Water Treatment Inspection		x	x	x	x	x	

NOTES:

1. Skills/blocks of instruction noted in the "All AFSC" column are those for which each AFSC must receive training. All AFSCs must know how to don and doff MOPP gear.

2. To those AFSCs to which this block of instruction applies, training will be specific to the scope of care/practice of the individual AFSC. Moreover, these skills may have unique requirements depending on the AFSC. For example, "Water Treatment Inspection" is unique to Public Health (4E0X1/43E3), BEE (4B0X1/43H3), IDMT (4N0X1-496), and Squadron Medical Element (4F0X1/48G3) AFSCs. Therefore, in this example, there is no need to include this block of instruction for those who hold the 4A0X1 AFSC.

3. These skills have different meanings and emphasis depending on the mission they support. Those who deploy to a Contingency Hospital have a different mission then those who deploy to a 2 echelon ATH. Thus, the small arms requirements for those at a CON Hospital are different then those at the ATH.

4. All sustainment training blocks are required annually except CPR which is required every two years.

Attachment 4

COMBAT ARMS REQUIREMENTS FOR DEPLOYING AFMS UNIT TYPE CODES

MEDICAL UTC	#OFF	#ENL	M-9	M-16	TOTAL REQUIRED
FFAAT	2	5	1	3	4
FFANC	3	6	2	4	6
FFBD1	0	12	0	6	6
FFBTP	1	11	1	7	8
FFBU1	0	6	0	3	3
FFCCA	3	0	3	0	0
FFCCE	2	1	3	0	3
FFCCT	2	1	3	0	3
FFCCU	7	13	3	9	12
FFDAB	1	3	1	3	4
FFDAD	1	3	1	3	4
FFEB1	70	151	32	68	100
FFEC1	84	203	35	85	120
FFGK1	8	15	5	10	15
FFGK2	12	17	8	11	19
FFGK3	14	30	10	20	30
FFGK4	5	23	3	15	18
FFGK5	13	36	9	24	33
FFGK6	7	4	4	3	7
FFGK7	7	4	4	3	7
FFGK8	0	3	0	3	3
FFGKE	67	147	34	74	108
FFGKF	30	90	15	45	60
FFGKH	30	43	15	25	40
FFGKN	0	2	0	2	2
FFGL1	1	5	1	5	6
FFGL2	3	1	3	1	4
FFGL3	1	4	1	4	5
FFGLB	0	19	0	19	19
FFGLE	1	12	1	12	13
FFGKU	4	2	4	2	6
FFGKV	3	1	3	1	4
FFGRL	3	3	3	3	6
FFGYN	3	3	2	2	2
FFHA1	4	2	4	2	6
FFHA2	8	7	4	4	8
FFHA3	3	11	1	5	6
FFHA4	1	2	0	1	1
FFHA5	2	0	1	0	0
FFLAB	10	29	16	23	39
FFLBD	6	21	2	5	7
FFLCA	22	64	5	15	20
FFLEA	41	139	11	34	45
FFLGD	0	6	0	3	3
FFPPT	1	1	0	1	1
FFPRM	10	12	10	11	22

MEDICAL UTC	#OFF	#ENL	M-9	M-16	TOTAL REQUIRED
FFQAC	4	4	4	4	8
FFQAD	3	5	3	5	8
FFQAE	1	6	1	6	7
FFQB9	10	15	25	0	25
FFQBB	0	2	2	0	2
FFQC1	2	0	2	0	2
FFQC3	4	1	5	0	5
FFQC4	2	1	3	0	3
FFQCE	20	30	50	0	50
FFQCK	2	3	5	0	5
FFQCQ	40	60	100	0	100
FFQCT	0	5	0	5	5
FFQCU	8	11	8	11	19
FFQCV	3	3	3	3	6
FFQCX	2	3	2	3	5
FFQCY	8	24	8	24	32
FFQDA	2	3	5	0	5
FFQDB	10	15	25	0	5
FFQDC	40	60	100	0	100
FFQDD	20	30	50	0	50
FFQEK	1	2	3	2	5
FFRAD	1	2	0	1	1

NOTES:

1. Weapons training will be in accordance with established guidance contained in AFPD 16-8, Arming of Aircrew, Mobility, and Overseas Personnel, AFI 31-207, Arming and Use of Force by Air Force Personnel, AFI 36-2226, Combat Arms Training and Maintenance (CATM) Program, this instruction, and other applicable directives.

2. There must be a minimum of one qualified individual for each weapon required. The ammunition authorized for each weapon is based on the personnel-arming requirement. For medical personnel specified here, munition authorizations for internal security, protection, and personal defense are as follows: M-16 rifle - 120 rounds and 9mm handgun - 30 rounds (per AFCAT 21-209, Ground Munitions, Para 3.13.1) AFCAT 21-209 also serves as the source for CMRT (per para 2.2.10) ground munitions authorizations.

3. Two handguns must be available for use by designated weapons couriers for each UTC with a weapons requirement. These handguns are reflected in the totals above.

4. Procure handguns (9mm) for officers and rifles (M-16) for enlisted personnel. ***EXCEPTION:*** Procure handguns (9mm) for aeromedical and medical crewmembers.

5. With limited exceptions, the ratio of handguns to rifles reflects the ratio of officers to enlisted required by UTC.

6. Bases assigned fragmented portions of UTCs will ensure their tasked personnel are weapons trained and qualified as required by the UTC. If the arming requirement is 100 percent for that UTC, then all personnel assigned by both the lead unit and any fragged portions, primaries and alternates, will be

weapon qualified. If the arming requirement is less than 100 percent, then the applicable percentage of personnel assigned will be qualified, as required by the UTC. The lead unit for identified taskings will ensure personnel in fragged UTCs supporting them have weapons available to support identified requirements. ***EXAMPLE:*** If the UTC requires 50 percent of total personnel be weapons qualified, then both the lead unit and any bases assigned a portion of that UTC will ensure that 50 percent of the total number of their personnel assigned to the UTC will be weapon qualified. Both the lead unit and any fragged units will ensure the applicable training requirement is met.

7. Units with in-place UTC taskings are exempt from weapons requirements except medical groups on the Korean Peninsula.

8. Medical groups on the Korean Peninsula will use the following guidance for determining weapons requirements:

51MDG – Use weapon requirements for FFGK2, FFGK4, FFGK5, FFGK6, and FFGK7 (total 84 weapons).

8 MDG – Use weapon requirements for FFGKH (total 40 weapons).

Attachment 5

MINIMUM COMMON CORE INSPECTION CRITERIA FOR AFMS UNIT TYPE CODES

(To be used in Operational Inspections/Exercises)

Standardized criteria ensures ALL Air Force Medical Service members, regardless of MAJCOM to which personnel are assigned, receive consistent evaluation/training.

FFQAC	Aeromedical Evacuation (AE) ADVON Team	Arranges support requirements and initializes operational command, control, coordination and communication for deployed AE activities. Decision making, direction, coordination, execution and reporting are accomplished in a timely manner Timely cross functional coordination and interaction occurs between command leadership, resource management and organizational control to accomplish mission objectives Adequacy and security of command, control, communications and computer procedures with other services, commands and users established Leadership and management actions positively impact mission accomplishment Appropriately identifies mission requirements and properly plans and executes to accomplish mission taskings
FFQAD	AE Squadron HQ	Establishes operational command, control, coordination and communication for deployed AE activities. Decision-making, direction, coordination, execution and reporting are accomplished in a timely manner. Timely cross functional coordination and interaction occurs between command leadership, resource management and organizational control to accomplish mission objectives Check adequacy and security of command, control, communications and computer procedures with other services, commands and users established Leadership and management actions positively impact mission accomplishment Appropriately identifies mission requirements and properly plans and executes to accomplish mission taskings

FFQAE	AE Group HQ	Establishes operational command, control, coordination and communication for deployed AE activities. Decision-making, direction, coordination, execution and reporting are accomplished in a timely manner. Timely cross functional coordination and interaction occurs between command leadership, resource management and organizational control to accomplish mission objectives Adequacy and security of command, control, communications and computer procedures with other services, commands and users established Leadership and management actions positively impact mission accomplishment Appropriately identifies mission requirements and properly plans and executes to accomplish mission taskings
FFLBD FFLCA FFLEA	ASF (ASTS)	Demonstrate ability to receive, assess, triage, stabilize, sustain and transfer patients Leadership and management actions positively impact mission accomplishment. Establishes and maintains a line of communication with line agencies, medical and aeromedical evacuation units (chain of command) Proficient in use of equipment Appropriate aeromedical patient disposition Maintains statistical data and provides reports to appropriate agencies
FFCCT FFCCA FFCCE FFCCU FFQC4 FFQC3	CCATT Trans Tm CCATT Air Augm CCATT Xtend SOF CCATT SOF MFST	Able to receive, assess, triage, stabilize and provide critical care to sustain patient on the ground and enroute to destination facility Maintain effective clinical leadership and communication with medical and aeromedical units Team members are proficient in operation of mission ready medical equipment used in support of aeromedical missions Appropriate patient status reporting complete upon transfer Provide resuscitative surgery support for AFSOC forces at a main operating base, collocated operating base, or other location forward of established health service support systems Demonstrates capability to provide resuscitative surgery and advanced trauma life support for 20 casualties for up to 48 hours of continuous operation Appropriately identifies requirements and arranges for local base operating support for extended operations beyond 48 hours

FFQBB/ HAAMS	High Altitude Airdrop Mission Support Team	Provides high altitude airdrop mission support Aerospace physiology technician provides in-flight physiology support to aircrew members and high altitude parachutists during high altitude insertions of personnel and equipment. Monitors personnel for in-flight physiology incidents, assists with loading and operation of supplemental oxygen equipment, and advises aircraft commander and jumpmaster on depressurization schedules, oxygen requirements and physiological hazards
FFQC1/2	AE FLT SURG	Demonstrate ability to receive, assess, triage, stabilize, sustain and transfer patients Clinical leadership and management actions positively impact mission accomplishment. Appropriate aeromedical patient disposition Appropriate status reporting complete upon transfer
FFQCU	AECC	Accomplish theater planning, coordinating, monitoring and execution of AE mission operations. Leadership and management actions positively impact mission accomplishment Establishes and sustains communication with line, user service medical and aeromedical evacuation elements Decision-making, direction, coordination, execution and reporting are accomplished in a timely manner. Assure cross functional coordination and interaction occurs between command leadership and resource management to accomplish mission objectives Identify and coordinate airlift request for patients and AE assets Maintains statistical data and provides reports to appropriate agencies
FFQCT	AE Support Cell	Demonstrates ability to sustain theater AE Elements as applicable: logistics, AGE, vehicle operations and communication equipment.

FFQCY	AE Operations Team	Accomplish day to day planning, coordinating, monitoring and execution of AE mission operations. Leadership and management actions positively impact mission accomplishment Establishes and sustains communication with line, user service medical and aeromedical evacuation elements Decision-making, direction, coordination, execution and reporting are accomplished in a timely manner. Assure cross functional coordination and interaction occurs between command leadership and resource management to accomplish mission objectives Identify and coordinate airlift request for patients and AE assets Maintains statistical data and provides reports to appropriate agencies Exercises operation control/crew management over tasked AE crews Prepare aircraft to meet daily AE mission tasking Maintains statistical data and provides reports to appropriate agencies
FFQCX	AE Crew Management Cell	Exercises operational control/crew management over tasked AE crews. Leadership and management actions positively impact mission accomplishment Maintains statistical data and provides reports to appropriate agencies
FFQCE FFQCK FFQCL FFQCQ FFQCS	AE Crews (Inter and Intra-theater)	Aeromedical Evacuation Crew Members (AECMs) receive, assess, triage, stabilize, sustain and transfer patients during ground and inflight operations. Establishes and maintains appropriate command, control and coordination with their chain of command. Leadership and management actions positively impact mission accomplishment Proficient in use of AE equipment AECMs configure the aircraft and safely enplane and deplane patients Patient report complete upon transfer

FFLAB	MASF	Demonstrate ability to receive, assess, triage, stabilize, sustain and transfer patients Leadership and management actions positively impact mission accomplishment. Establishes and maintains a line of communication with line agencies, medical and aeromedical evacuation units (chain of command) Proficient in use of equipment Appropriate aeromedical patient disposition is determined Maintains statistical data and provides reports to appropriate agencies Exercises operation control/crew management over tasked AE crews Establishes and maintains lines of communication and provides security of command, control, communications and computer procedures with other services, commands and users Check adequacy and security of command, control, communications and computer procedures with other services, commands and users Appropriate aeromedical patient disposition Maintains statistical data and provides reports to appropriate agencies
FFQCV	Aeromedical Evacuation Liaison Team (AELT)	Establishes and maintains communication and coordination with AE elements and the user service to provide optimum aeromedical evacuation of casualties. Advises user service on clinical and administrative preparation of patients for AE Leadership, management and operational control positively impact mission accomplishment. Maintains statistical data and provide reports to appropriate agencies FCC assures administrative and clinical patient preparations are complete prior to patients transport to staging

	All AE UTCs	Initial Response (Universal to all AE UTCs): Provides overall command, control coordination and mission CONOPS to all tasked functional areas. Tasking message received and understood Proper OPSEC/COMSEC/COMPUSEC enforced Required reporting is accurate and timely (i.e., MEDREDS, SITREP, etc.) Essential intelligence information received and disseminated in a timely manner Emergency action procedures completed in an effective and timely manner Personnel, equipment and materiel are mobilized and deployed to meet mission taskings and timelines Coordinated and maximized utilization of transportation resources Coordinates load planning to assure the safe and timely deployment of tasked resources All closure requirements and reports completed on time
FFAAT	Medical Management Aug.	Will provide patient visibility and prep for evacuation
FFBD1	Frozen Blood Product Team	Thaw, deglycerize, wash and label two units in one Hour
FFBU1	Blood Supply Unit Aug Team	Demonstrate handling and supply skills Product Handling Admin Tasks Transportation Requirements
FFDAB	Med Air Transportable Clinic (ATC)	Determine availability of, or arrange hospital & AE Support Establish resupply mechanism Maintain accountability of controlled substances Comply with surveillance and reporting mechanisms Manage Aerospace Physiological Incident Meets 2E Medical ORI standards
FFDAD	Med Support Element BP 300-500	Determine availability of, or arrange hospital & AE Support Establish resupply mechanism Maintain accountability of controlled substances Comply with surveillance and reporting mechanisms Meets 2E Medical ORI standards

FFDAE	Med USAF Associate Clinic	Meets 2E Medical ORI standards
FFEB1	First 75 Bed Increment of CONHOSP, ADVON Team	Evaluate medical & surgical 2E & 3E DEPMEDS condition management Demonstrate competent management of DEPMEDS conditions in dental and combat stress support Establish resupply mechanism Maintain accountability of controlled substances Comply with surveillance and reporting mechanisms
FFEB2	250 Bed Hospital Augmentation	2E & 3E surgical standards Demonstrate mission knowledge Meet general medical UTC ORI criteria
FFEC1	500 Bed 3E Hospital Team 1	Apply medical, surgical, dental, MH 2E & 3E standards Demonstrate competent management of DEPMEDS conditions Establish resupply mechanism Maintain accountability of controlled substances Comply with surveillance and reporting mechanisms
FFEC2 FFEC3 FFEC4 FFEC5	500 Bed 3E Hospital Teams	Demonstrate 2E & 3E mission competence Demonstrate mission knowledge
FFGK1	Medical Support Personnel	Determine Availability of, or Arrange Hospital & AE Support Establish Resupply Requirements Maintain Accountability of Controlled Substances Demonstrate Knowledge of Reporting Requirements Establish Surveillance System Specifically Demonstrate Standard ORI Preventive Medicine Activities Meets 2E Medical ORI Criteria
FFGK2	Medical 25 Bed ATH Personnel	Echelon 2 and 3 Clinical ORI Criteria Functional Evaluation of Patient Visibility Evaluate DEPMEDS Condition Management of Lab (to include emergency blood collections), X-Ray, Pharmacy, Dental Care, and Nursing Care, associated with ORI Criteria Evaluate DEPMEDS Condition Management for Pt Evacuation

FFGK4	Medical 50 Bed ATH Personnel	Echelon 2 and 3 Clinical ORI Criteria Functional Evaluation of Patient Visibility Evaluate DEPMEDS Condition Management of Lab (to include emergency blood collections), X-Ray, Pharmacy, Dental Care, and Nursing Care, associated with ORI Criteria Evaluate DEPMEDS Condition Management for Pt Evacuation
FFGK5	10 Bed Air Transportable Hospital Personnel	Evaluate Care of 2E & 3E non-Surgical DEPMEDS Conditions Evaluate Surgical & Nursing Care when FFGK6/7 Under Evaluation Evaluate Emergency Services, Dental, Lab (to include emergency blood collections), Pharmacy, X-Ray, Nursing Care Evaluate DEPMEDS Condition Management for Pt Evacuation
FFGK6 FFGK7	ATH Surgical Teams	Definitive (3E) Surgical Stabilization Evaluate DEPMEDS Conditions in Gen Surgery and Orthopedics Includes Nursing Care Assessments Evaluate DEPMEDS Condition Management for Pt Evacuation
FFGK8	Squadron Medical Element (SME) Augmentation	IDMT: Demonstrates Basic Trauma Life Support Skills Includes Management in Contaminated Environment BEE & PH Technician skills: Demonstrate Food Safety Program Demonstrate Vector and Disease Surveillance Skills Demonstrate Air and Water Monitoring Skills Demonstrate Industrial Hygiene & Environmental Protection Evaluation Skills All: Demonstrate communicable disease surveillance, prevention and control.
FFGKE	Hospital 125 Bed Expansion	Evaluate Accomplishment of Universal and Medical ORI Criteria for 3E DEPMEDS Patient Conditions
FFGKF FFGKH	Hospital Expansion Package	Evaluate Functional 3E DEPMEDS Condition Patient and Evacuation Management Includes Surgical DEPMEDS Conditions Includes Nursing Post-Surgical Care

FFGLB	Patient Decontamination Team	Demonstrate ability utilize detection equipment in FFGLA to ensure proper decontamination of casualties/equipment prior to movement into a clean area Demonstrate Basic Life Support Skills During Patient Decontamination Process Demonstrate that Team can identify contamination, and ascertain decontaminated state Demonstrates proficiency in patient/medical personnel decontamination NOTE: FFGLA, which is a DECON equipment package, will be assessed w/this team
FFCCU	4-Bed Intensive Care Unit	Will unpack equipment and demonstrate intimate familiarity with it Will demonstrate hemodynamic monitoring skills Will calculate preload & after-load parameters Will demonstrate initial ventilator settings Will adjust ventilator settings based on changed ABG exercise input
FFENT FFEYE FFGKT-FFGYN-FFNEU FFPPT FFPRM	Otolaryngology Ophthalmology Thoracic/Vascul Gynecology Neuro Urology Primary Care	Demonstrate UTC specialty specific equipment, and its operation to the Medical Inspector Demonstrate proficiency in standardized stabilization ORI clinical criteria Oral Surgeon will demonstrate the operation of the anesthesia machine and dental chair and components
FFRAD	Ancillary Augmentation (Fluroscopy)	Demonstrate interpretive skills Demonstrate equipment familiarity
FFANC	Ancillary Augmentation (Radiology, Pharmacy, & Laboratory)	Demonstrate interpretive skills Use pre-standardized films Demonstrate Telemedicine support in Teleradiology When available Demonstrate equipment familiarity
FFLGC	Theater Blood Donor Center	Demonstrate Equipment Familiarity Draw, process, and ship 20 units of each tasked blood component (Blood, PRBC, Plasma, Whole Blood, Red Blood Cells, and Platelets) for demonstration purposes Demonstrate blood safety testing if in Combat Zone Not required if FDA licensed and in-place generated

FFMAX FFPDD FFPER FFEND	Maxillofacial Pedodontia Periodontia Endodontia	Generalized ORI criteria Demonstrate Triage, BLS, and ACLS skills Does not need to demonstrate ATLS skills
FFTEL FFTMF	Telemedicine Telemed Forward	Will meet generalized ORI criteria Sample of functionals from collocated facility will demonstrate How to use Telemedicine units if/when available
FFGL1	BEE/NBC	Demonstrates ability to evaluate health risks, protection requirements and abatement Demonstrates ability to communicate health risk and control measures to the SRC & MCC
FFGLE	PATIENT RETRIEVAL	13 man (60% min 4N0s) retrieval team Demonstrate ability to transport patients in a safe and effective manner Demonstrate ability to provide BTLS (EMT) Demonstrates ability to documents pt care
FFGKUF FGKV	Mental Hlth Aug Rapid Response	Demonstrates technical and proactive mental health support for contingency operations Demonstrates familiarity w/BICEPS principles Demonstrates knowledge of combat stress, CISD, crisis intervention modalities and brief therapy techniques Demonstrates proficiency in intervening in situations involving misdirected violence, cultural dislocation and adjustment issues in the deployed locations Demonstrates ability to perform innovative preventive measures that enhance the CCs ability to successfully execute his/her mission
FFGL2 FFGL3	Preventive and Aerospace Medicine Teams	Demonstrate ability to provide public health, occupational, environmental, and disease surveillance, intervention, and abatement Demonstrate ability to help establish base infrastructure Health threat/risk assessment Health hazard surveillance Health hazard control & mitigation of effects
FFHA1	EPI TEAM	Demonstrate ability to provide theater level epidemiology based support to deployed medical teams Baseline health & environmental risk assessment Outbreak investigation Surveillance policy recommendations Environmental and occupational health sampling and interpretation Related Contingency References - AFI 48-Series

FFHA3	THEATER REFERENCE LAB TEAM	Demonstrates ability to provide advanced diagnostic reference laboratory support to deployed theater medical assets
FFHA2	INFECTIOUS DISEASE TEAM	Demonstrates ability to identify, control and treat infectious diseases Identifies confirms, and reports use of biological warfare agents Educates deployed medical staff on infectious control practices and procedures
FFHA4	CT Scan Team	Demonstrates ability to set up and operate equipment
FFLGD	Blood Transshipment Center Team	Demonstrate transshipment skills Product handling Administrative tasks Transportation requirements
FFBTP	Transportable Blood Transshipment Center	Demonstrates site selection/inspection/preparation to include securing water, power, fuel and forklift Demonstrates TBTC sustainment of operations including, but not limited to: Preventive maintenance of equipment; Inspection of isolation shelters for structural integrity; Verification of electrical system functionality; and Ensuring communications remain functional Receive briefings on ASBPO, field blood reports, core values, pillars and competency, current doctrine and TDBSS Demonstrates capability to receive/process/ship frozen and fresh products, process field blood reports, operate the control panel, operate the ice machine, properly build pallets Demonstrates redeployment capability to include: Repacking the Conex; Repacking the Titan Bins; Repacking stored items into the ISO Shelter; Proper jack removal procedures; Drying/repacking/storing the RSSA tentage; Palletizing equipment/supplies, as required; and Marshalling same to storage
AFSOC UTC FFQEK	Special Operations Forces Medical Element (SOFME)	Demonstrate capability to provide medical support for SOF units under varying conditions, including austere environments Demonstrate capability to provide primary care, force sustainment, Advanced Trauma Life Support (ATLS), Advanced Cardiac Life Support (ACLS), preventive and aerospace medicine, and casualty evacuation (CASEVAC) from forward areas to the SOF air-ground interface point Maintain required clinical/technical certification and accomplish training requirements as outlined in the AFSOC Medical CONOPS

NOTE: As manpower and force packaging requirements are revised, as well as mission capabilities statements, units will extrapolate applicable information from mission descriptions to develop listings of common core inspection criteria subject to review during the operational inspection process.

Attachment 6

MINIMUM MEDICAL READINESS EXERCISE REQUIREMENTS

EXERCISE REQUIREMENT	FREQUENCY	AUDIENCE	REFERENCE	REMARKS
Major Accident Response Exercise	Quarterly	Scenario Dependent	AFI 32-4001, Base OPLAN 32-1	* Mass Casualties Once/Year * One Mass Casualty Involving Chem/Bio Casualties * One Exercise After Normal Duty Hours * One Nuclear Weapon Response
Attack Response Exercise	2X Annually (Installations in Chem/Bio Threat Area) Annually (Installations in Chem/Bio Non-threat Area)	Scenario Dependent	AFI 32-4001	
Natural Disaster Response Exercise	Annual	Scenario Dependent	AFI 32-4001	Natural Disaster Response Typical to Unit Area
Mobilization Exercise	Annual	All Assigned To Deploy-ment Status and Deploy-ment Teams	AFI 10-402, AF Pamphlet 10-219, Vol 1, AF Pamphlet 10-417, AFI 10-403, AF Handbook 10-416	Exercise Entire Range of Deployment Responsibilities
Recall	IAW Base/Wing Exercise Sched-ule and Com-mander Discretion	Scenario Dependent		Evaluate Capability to Implement Unit Recall Plan

EXERCISE REQUIREMENT	FREQUENCY	AUDIENCE	REFERENCE	REMARKS
Assemblage Set Up, Inventory, and Exercise	Annual	All Personnel Assigned to Work In Applicable WRM Assemblage	DoDI 1322.24, AFI 41-106	Train to Extent Possible for Equipment/ Assemblage Proficiency
Alternate Medical Treatment Facility	Biennial	Scenario Dependent	AFI 41-106	
Field Exercise/Training	Annual	All	DoDI 1322-24, AFI 41-106	RC field exercise training will be conducted on a 4 yr cycle
NDMS	Annual	Scenario Dependent		Exercise Involvement Driven by Federal Coordinating Centers

Attachment 7

SAMPLE FIELD TRAINING SCHEDULE FOR MEDICAL UNITS

STARTEX

DAY ONE

TIME	A-SHIFT	B-SHIFT
0530-0600	Deployment Processing	Deployment Processing
0630-0730	Concept of Operations/USAF Medical Service Mission	Concept of Operations/USAF Medical Service Mission
0730-0800	Site Selection	Site Selection
0830-0930	Transportation to CMRT Field Site	Transportation to CMRT Field Site
0930-1230	Field Gear Issue/Camp Set-Up	Field Gear Issue/Camp Set-Up
1230-1330	Lunch	Patient Transportation
1330-1430	C4I	Lunch
1430-1530	Patient Retrieval	NBC Medical Defense
1530-1630	Patient Retrieval	Force Health Protection
1630-1730	Litter Obstacle Course	Land Navigation
1730-1830	Dinner	Site Security
1830-1930	Casualty Management	Dinner
1930-2030	Casualty Management	Air Force Blood Program
2030-2130	Casualty Management	C4I
2130-2230	Force Health Protection	Geneva Convention, LOAC, and Code of Conduct
2230-2330	Night Operations	Night Operations
2330-2400	Night Operations	Night Operations
2400-0600	Off-duty	Off-duty

DAY TWO

0600-0700	Patient Transportation	Breakfast
0700-0800	Breakfast	Wartime Stress
0800-0900	NBC Medical Defense	Patient Retrieval
0900-1000	Site Security	Patient Retrieval
1000-1100	Air Force Blood Program	Litter Obstacle Course
1100-1200	Geneva Convention, LOAC, and Code of Conduct	Lunch
1200-1300	Lunch	Casualty Management
1300-1400	Wartime Stress	Casualty Management
1400-1500	Land Navigation	Casualty Management
1500-1600	Mass Casualty Exercise	Mass Casualty Exercise
1600-1700	Mass Casualty Exercise	Mass Casualty Exercise
1700-1730	Critical Debrief	Critical Debrief
1730-1900	Site Tear-Down/Equipment Turn-In	Site Tear-Down/Equipment Turn-In
1900-1930	Return to Home Base	Return to Home Base

ENDEX